

# **STATE TITLE V BLOCK GRANT NARRATIVE**

**STATE: ND**

**APPLICATION YEAR: 2006**

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## **I. GENERAL REQUIREMENTS**

### **A. LETTER OF TRANSMITTAL**

The Letter of Transmittal is to be provided as an attachment to this section.

### **B. FACE SHEET**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

### **C. ASSURANCES AND CERTIFICATIONS**

Signed assurances and certifications will be maintained on file in the North Dakota Department of Health, Division of Family Health. As required in Section 502(a)(3), funds will only be used for the purposes specified. As required in Section 505(a)(5)(B), funds will only be used to carry out the purposes of this title.

### **D. TABLE OF CONTENTS**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

### **E. PUBLIC INPUT**

In fall 2004, a Title V planning retreat was held with over 40 individuals representing each of the three MCH population groups. Needs assessment data was presented, and with the help of a facilitator, health needs were prioritized and intervention strategies and partner opportunities discussed. Input obtained at the retreat was used in subsequent planning for the FY 2006 application.

Both the CSHS Family Advisory Council and Community Health Section Advisory Committee provided input into the application. After Title V staff shared information related to the planning process, council members made suggestions for changes to priority needs and performance measures. Members of the CSHS Family Advisory Council also provided input for the FY 2006 Annual Plan and participated in the rating of the characteristics to assess family participation in the State CSHCN program. Family rankings were averaged with CSHS staff rankings to derive the overall ranking reported for FY 2004. The CSHS Medical Advisory Council was also updated on the five-year Title V needs assessment and planning activities at its May 2005 meeting.

In June 2005, a news release was sent to most major media outlets in the state. The release provided information about priority needs that had been identified for the MCH population through the statewide needs assessment and announced that the Title V application would be available for public comment on July 8, 2005.

## **II. NEEDS ASSESSMENT**

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

### **III. STATE OVERVIEW**

#### **A. OVERVIEW**

North Dakota (ND) is a large state on the northern edge of the Great Plains abutting the Canadian provinces of Saskatchewan and Manitoba. It is positioned neatly between Montana and Minnesota and sits on the northern border of South Dakota. The state is 212 by 360 miles and occupies a landmass equivalent to the that of New York, New Jersey, Massachusetts and Connecticut (70,704 square miles) with a mere fraction of the population of these more urban states. It is 17th in the nation for size and 47th in the nation for population. The average population density for the United States is 79.6 persons per square mile compared to ND's 9.3 persons per square mile.

The relative isolation of ND's rural population is demonstrated by the fact that nearly 68% of the landmass in the state is considered frontier, with a population density less than six persons per square mile. This means a wide dispersion of the rural population and significant distances from rural to more populous areas. Travel to population centers for health care or for other purposes often entails significant amounts of time and effort for rural residents. Compounding this issue is the virtually non-existent mass transportation system. The automobile is the primary means of transportation for most rural and urban residents. While a number of mini-bus services have been developed over the years for the elderly and disabled residents, the services are regional and usually client-specific. There is limited Greyhound bus service and Amtrak service is only available through the northern tier of the state. This leaves most rural residents to rely on private automobiles for their primary transportation to access goods and services. Obviously, this is a significant problem for adolescents and low-income rural population groups.

The problem of isolation and travel difficulties for many ND rural residents is complicated by weather conditions in the state. As a state located in the geographic center of North America, the weather patterns can be extreme. Meteorologists point out that the farther an area is from oceans, the more variation there will be in the climate. ND is as far from oceans as any state in the nation. Temperatures range from highs of 109 degrees [with heat indexes up to 125 degrees] in the summer to lows of -43 degrees [with wind chills of -100 degrees] in the winter. Winter conditions are perhaps of more concern due to the more immediate jeopardy to human life that it can present. The absolute cold of winter compounded by the wind chill factors can freeze unprotected human flesh in less than one minute. Frequently, blowing snow makes travel hazardous and at times impossible.

This is not to say that ND is a forbidding place to live. It is a beautiful state with many extraordinary geographical features and is populated by hardy residents who understand the difficulties and the hazards of winter travel. Travel for many rural ND residents takes more planning and coordination in order to access health care services than for their counterparts in many other states in the nation.

There are several hard demographic truths about the future in ND: 1) population consolidation, 2) loss of young adults/families, 3) aging population, and 4) shifting labor force.

ND lost 1.6% of its population between 1980 and 2000, but not all counties lost population. Population growth was concentrated in Cass, Grand Forks and Burleigh counties. Smaller levels of growth were experienced in Sioux, Mercer, Ward and Rolette counties. All other counties lost population. Although adjacent and remote counties lost a significant share of their populations, the metro areas grew by 17.3% from 1980-2000.

Rural-Urban Population Distribution  
ND, 1900-2000 (see attachment)

Less than four percent of the United States population lives in frontier areas spread over more than half of the country's land mass. However, over 21% of the ND population resides in the 36 counties designated as frontier. Frontier counties are categorized as persistent poverty counties. Economic characteristics of frontier areas impacting women and children include occupational hazards, poverty, lack of health insurance and lack of health care resources. Economic stress is also highly correlated

with clinical depression and family stress.

One of the most significant issues faced by rural ND communities and health care providers is the out migration of the state's rural population. The effect of this demographic trend is profound. It influences all aspects of life in rural ND. The decline is associated with reductions in rural tax bases, business enterprises, social activities and bears heavily on the difficulty in sustaining local educational institutions and health care facilities, personnel and programs. The decline is not a recent phenomenon. It began over 50 years ago and will likely continue into the foreseeable future. To complicate matters, the decline is not uniformly distributed across all age groups. It is primarily associated with "working age" people (20-50 years old) who move from rural areas to secure employment or other opportunities out of state or in the population centers of ND. The net effect of this population trend is continued reduction in the number of people that live in most ND counties and a general "aging" of the population that remains in rural areas. However, that does not relieve public health programs from the responsibility of providing services to North Dakotans in these remote areas. This population trend presents a significant challenge to providing health care in rural ND.

As is characteristic of rural states, the annual per capita personal income is below the national average. It may be noted that, when controlling for inflation, ND compared to the United States and the three surrounding states, but still lags behind the national average [only 85% of the U.S. average] and two of the three bordering states ranking 39th nationally. All but one county within ND has per capita income lower than the national average. Forty-six of the 53 counties have per capita incomes lower than the state average. Per capita income stands at \$17,769 for ND compared to the national average of \$21,587.

Considering that agriculture comprises a significant portion of the state gross product, it is understandable that there can appear to be significant fluctuations in the per capita income from year to year. The boom/bust phenomenon in the energy industry in years past has had a significant impact on the economic status of North Dakotans in the western part of the state. Due to the problems in these two major industries, the ability of individuals to purchase health care services has decreased since the more basic needs of shelter and food have become the priority in their lives.

The 2000 Census indicates that 11.9% of the population lives in poverty. Statistics for 2001 indicate that the proportion has risen to 13.8%. This represents a fairly equal rise in both the number of males and females below the poverty level. However, 15.8% of all females are below poverty as compared to 13.0% of all males. This trend has not significantly changed over the intervening years leading to the year 2000 Census.

The state population of 638,800 is primarily Caucasian - 593,181 or 92.4% of the citizens fall into this category. Minority populations comprise 49,019 or 7.6% of North Dakotans. American Indians are the most significant minority group in ND totaling 31,329 individuals. Members of this ethnic group may be found either on one of the five reservations within ND or scattered across the state in the major cities. They are also the ethnic group with the most significant health care problems, but also the most difficult to reach and provide services to due to their cultural considerations.

American Indians living on the reservation have access to Indian Health Service (IHS) as well as Tribal Health Services (THS) for their health care services. There has been continued collaboration between the five tribes in ND, the North Dakota Department of Health (DoH) and the North Dakota Department of Human Services (DHS) in addressing health issues. The more difficult population of American Indians to reach are those residing in the major cities of ND. They have more limited access to IHS and THS for health care services and are less likely to be able to afford unsubsidized care.

## State and Departmental Priorities and Initiatives

Initiatives of Governor John Hoeven's Administration focus on the following six pillars: education, economic development, agriculture, energy, technology and quality of life. In Governor Hoeven's 2002 State of the State address, he announced a new public health initiative, Healthy North Dakota, which

focuses on improving the health of every North Dakotan. First Lady Mikey L. Hoeven has been deeply committed to addressing women and children's issues in the state of ND. She is especially active in women's health, the prevention of underage drinking, and is the official spokesperson for Healthy North Dakota. More information is available at: <http://www.firstlady.state.nd.us>

Healthy North Dakota is a statewide initiative whose goal is to improve the health of every North Dakotan by inspiring people to establish personal behaviors and support policies that improve health and reduce the burden of health care costs. Healthy North Dakota works through innovative statewide partnerships to support North Dakotans in their efforts to make healthy choices - in schools, workplaces, senior centers, homes and anywhere people live, work and play. At an August 2002 Healthy North Dakota Summit, 130 people representing more than 75 organizations met to define wellness and identify priorities for ND. The input gathered at the summit provided the framework for a statewide wellness plan. The following topics have been identified as priorities for ND: 1) tobacco use, 2) substance abuse/mental health, 3) healthy weight/nutrition, 4) healthy weight/physical activity, 5) health disparities, 6) worksite wellness, 7) community engagement, 8) third-party payers/insurance, 9) oral health, 10) cancer, 11) early childhood, 12) school health, 13) aging, 14) immunizations, 15) cardiovascular health, 16) injury prevention and control, and 17) diabetes.

The DoH is dedicated to ensuring that ND is a healthy place to live and that each person has an equal opportunity to enjoy good health. The Department is committed to the promotion of healthy lifestyles, the protection and enhancement of health and the environment, and the provision of quality health care services for the people of ND by networking, facilitating local efforts, collaborating with partners and stakeholders and providing expertise in developing creative public health solutions.

The DHS is an umbrella agency with the mission to provide quality efficient and effective human services, which improve the lives of people. An Executive Director who is appointed by the governor heads the department. Broad-based goals of upper management are: 1) to focus attention on the Department's mission, 2) to improve teamwork across the department, 3) to improve innovation/creativity within the department, 4) to establish performance measures and accountability, and 5) to develop a proactive legislative agenda.

The department last underwent a strategic planning process in 2004. Plans that were developed as a result of that process continue to serve as a basis for evaluating achievements and include measures to ascertain the quality, efficiency and effectiveness of DHS programs.

ND's Title V statewide needs assessment process for FY's 2006-2011 began in 2003 and continued through March 2005. After an initial planning and data collection phase, a statewide meeting of key stakeholders was convened to assist in the selection of priority needs. Further work concluded the process by setting performance measure targets, identifying activities and allocating resources. The following ten priorities were identified through the statewide needs assessment process: 1) to increase physical activity and healthy weight among women, 2) to increase the initiation and duration of breastfeeding, 3) to increase access to dental services for low-income women, 4) to increase access to preventive health services for women, 5) to reduce the rate of intentional and unintentional injuries among children and adolescents, 6) to increase physical activity among pre-school and school-age children, 7) to increase the percent of healthy weight among children and adolescents, 8) to reduce the impact of chronic health conditions on children, 9) to improve geographic access to pediatric specialty care providers, and 10) to increase information and awareness about available services.

Title V resources are directed towards these ten priority areas. Many of these priority areas are also being addressed through Healthy North Dakota workgroups, in which MCH program staff are active members.

In April 2001, ND received a three-year, point-in-time Pregnancy Risk Assessment Monitoring System (PRAMS) grant. The first two years of the grant involved selection of a contractor, development of the survey tool, determination of sampling strategy, initiating the survey and the start of data analysis.

Year three concluded in March 2005 with the release of "North Dakota PRAMS -- 2002 Survey Results." The report is available online at <http://www.ndsu.edu/sdc/data/ndprams.htm>. Data from this survey was instrumental in the state's five-year needs assessment.

The 59th Legislative Assembly organized December 6-8, 2004, and met in regular session from Tuesday, January 4, 2005, through Saturday, April 23, 2005 and consisted of a Senate with 47 senators and a House of Representatives with 94 representatives. There were 944 bills (531 in the House and 413 in the Senate), 100 concurrent resolutions (60 in the House and 40 in the Senate), and two memorial resolutions introduced during the regular session. Of the total 1,046 bills and resolutions introduced, 333 House bills, 282 Senate bills, 42 House concurrent resolutions, 32 Senate concurrent resolutions, and one House and one Senate memorial resolution passed. The Governor signed 612 bills into law. He vetoed six bills, all of which were sustained. Three vetoes were item vetoes and did not affect the entire bill. Thus, 612 of the 615 bills have or will become law.

The Healthy North Dakota collaborative representing more than 400 North Dakotans and more than 150 different agencies, organizations and businesses provided leadership in identifying legislative strategies necessary to build a Healthy North Dakota. Healthy North Dakota partners worked collectively to identify key prevention policies prior to the legislative session, and as a result, a cohesive approach to raising the visibility of prevention was achieved. Through the Healthy North Dakota collaborative, silos are softening, which is leading the state to a cohesive, consistent approach to prevention.

Numerous bills relating to the maternal and child population were considered by the Legislature. Those most significantly related to the MCH population include:

HB 1101: Relating to personal floatation devices for children on vessels. (Failed)

HB 1012: An Act to provide an appropriation for defraying the expenses of the DHS; to provide an exception; to provide for a legislative council study; to provide an appropriation to the DoH; to provide for a transfer to the general fund; to provide for the transfer of appropriation authority; to create and enact a new section to chapter 25-18 of the ND Century Code, relating to providing services to medically fragile children; to amend and reenact subsection 10 of section 54.44.8-01 of the North Dakota Century Code (NDCC), relating to telecommunications equipment; and to declare an emergency. (Passed)

Some of the areas where additional funding will positively impact the DHS follows below:

- \* DHS will be able to replace the Medicaid Management Information System (MMIS).
- \* Funding was included to address a decrease in the federal match for Medicaid (FMAP).
- \* Funding was included to help some people with developmental disabilities to transition from the Developmental Center to community-based care settings.
- \* Uniform inflationary increases for various provider groups were included in the DHS appropriation bill.

HB 1048: Relating to required high schools units. This bill decreased the required units offered in physical education and health. (Passed)

HB 1148: Relating to personal care services for eligible medical assistance recipients who are residing in their own homes. Makes permanent the personal care option for individuals eligible for the Medicaid Program. It also requires the department to submit a waiver that would permit disabled and elderly individuals to direct their own care. (Passed)

HB 1227: Relating to the protection of a preborn child and the duty of physicians; and to provide a penalty. (Failed)

HB 1206: Relating to provider appeals of medical assistance reimbursement denials; and to amend and reenact section 50-24.1-15 of the NDCC, relating to pre-hospital emergency medical services. Establishes an appeal process for providers who do not agree with the payment decision made by staff of the Medicaid Program. The provider can appeal a decision to the Department and an individual who was not involved in the original decision must complete the review process. If the provider does not prevail, he then could appeal directly to the district court. (Passed)

HB 1320: Relating to recess for elementary students. (Failed)

HB 1342: Relating to all terrain vehicles. (Passed)

HB 1383: Relating to definitions for the purpose of sale and consumption of alcoholic beverages. (Passed)

HB 1412: Relating to passengers on all-terrain vehicles. (Passed)

HB1456: Relating to employers' responsibilities for nursing mothers. (Failed)

HB 1459: Relating to creation of a prescription drug monitoring program and medical assistance program management; to provide for reports to the legislative council; to provide for a legislative council study; to provide legislative intent. Establishes a drug-monitoring program contingent on the availability of federal funds to implement the program. Establishes a disease management program for Medicaid recipients with a concentration given to individuals with high medical costs. It also requires the Department to report to the Legislative Council on various issues relating to the operation of the Medicaid Program and recommends a study of the Medicaid reimbursement system. (Passed)

HCR 3013: A concurrent resolution directing the Legislative Council to study the causes of and factors that reduce the severity of motor vehicle crashes. (Passed)

HCR 3017: Urging Congress to pass a human life amendment to the Constitution of the United States. (Passed)

HCR 3022: A concurrent resolution directing the Legislative Council to study data regarding cervical cancer and human papillomavirus, evaluate current methods of public education and access to regular cervical cancer screening, and consider options for increasing screening accuracy. (Passed)

HCR 3034: A concurrent resolution urging school districts to provide a midmorning and midafternoon recess to all students in kindergarten through grade six. (Passed)

HCR 3046: A concurrent resolution directing the Legislative Council to study the feasibility and desirability of implementing early childhood education programs. (Failed)

HCR 3051: A concurrent resolution directing the Legislative Council to study ways in which state agencies can join with health care professionals, school districts, schools and parents to promote understanding regarding the interplay of health and educational success and to improve the health and well-being of elementary and high school students in this state. (Failed)

HCR 3054: A concurrent resolution directing the Legislative Council to study state programs providing services to children with special health care needs to determine whether the programs are effective in meeting these special health care needs, whether there are gaps in the state's system for providing services to children with special health care needs, and whether there are significant unmet special health care needs of children which should be addressed. (Passed and selected as an interim legislative study)

SB2004: An Act to provide an appropriation for defraying the expenses of the DoH relating to the state health officer's duty to establish an environmental review process for commercial buildings; relating to licensure of food vending machines, beverage sales, food and lodging establishments, assisted living facilities, pushcarts, mobile food units, salvaged food distributors, bed and breakfasts, mobile home parks, trailer parks, and campgrounds; relating to license fee amounts for beverage sales, food and lodging establishments, mobile food units, pushcarts, bed and breakfasts, mobile home parks, trailer parks, and campgrounds; to provide for a report to the legislative council; to provide legislative intent; and to provide for a legislative council study. (Passed)

Some of the areas that will positively impact the DoH follow below:

- \* One new FTE for the Division of Tobacco Prevention and Control (funded by the tobacco settlement dollars)

- \* Authority to spend \$220,000 for abstinence education programs.

- \* Authority to spend \$135,000 for worksite wellness pilot.

- \* Legislative Council study on the costs and benefits of adopting a comprehensive Healthy North Dakota and workplace wellness program.

SB 2067: Relating to the use of alcohol by a person under twenty-one years of age. (Passed)

SB 2163: Relating to student's possession and self-administration of medication for the treatment of asthma and anaphylaxis. (Passed)

SB 2185: Relating to buy-in of medical assistance for individuals with disabilities. Makes permanent the workers with disability program including clarifying the allowance of an additional \$10,000 in assets for this group. (Passed)

SB 2205: Relating to snowmobile registration and snowmobile operation by an individual who is at least twelve years of age. (Passed)

SB 2208: Relating to motor vehicle child restraint systems. (Passed)

SB 2223: Relating to the distribution of tobacco settlement moneys and tobacco tax revenue; and to provide a continuing appropriation. (Failed)  
SB 2261: Relating to legal protection to moms who breastfed in public. (Failed)  
SB 2300: Relating to smoke free environments, relating to smoking area signage; and to provide a penalty. (Passed)  
SB 2308: Relating to consent for certain health care services provided to minors. (Failed)  
SB 2328: Relating to a limitation on the sale of certain beverages on school property. (Failed)  
SB 2380: Relating to the use of safety belts: relating to secondary enforcement of safety belt violations. (Failed)  
SB 2395: Relating to a DHS treatment program for children with Russell-Silver syndrome; to amend and reenact subsection 12 of section 50-10-06 of the NDCC, relating to income eligibility for Russell-Silver syndrome treatment and services; to direct the DHS to apply for a medical waiver; to provide for a legislative council study; to provide for a report to the legislative council; to provide an appropriation; and to declare an emergency. (Passed)  
SB 2409: Relating to the establishment of an alternatives-to-abortion services program; to provide for reports to the legislative council; to provide an appropriation; and to provide an expiration date. (Passed)

## Health Care Coverage

ND has been funded by HRSA for a second year of funding under the State Planning Grant Program. The current grant period, 8/1/04 to 8/31/05, includes \$162,196. ND has received a total amount of \$944,085 during fiscal years 2003 and 2004 through this program. The purpose of the grant program is to study health insurance coverage in the state and to develop options and plans for expanding health insurance coverage for the uninsured. Forty-six states have received funding through the State Planning Grant Program. Dr. John R. Baird, state medical officer, oversees the grant and coordinates the Governor's Health Insurance Advisory Committee (GHIAC). The Center for Rural Health, University of North Dakota (UND) School of Medicine and Health Sciences, coordinates the research component. A household phone survey, four household focus groups, an uninsured focus group and four employer focus groups have been conducted. In addition, health insurance questions have been added to a ND Job Service survey that was distributed to ND employers during May 2005 to identify opportunities and barriers that employers encounter pertaining to providing and/or offering health insurance coverage for their employees. The GHIAC has examined the experience of other states and reviewed ND's medical marketplace. Governor Hoeven requested that the GHIAC's policy recommendations be budget neutral. Overall, 8.2% of North Dakotans do not have health insurance. Of the approximately 51,900 North Dakotans who are uninsured, most uninsured tend to have lower incomes, and work in small firms that have 10 or fewer employees. American Indians are the most likely population in ND to be uninsured with almost 32% of American Indians reporting they are uninsured compared to 6.9% of the Caucasian population. A report will be filed with the Secretary of Health and Human Services (HHS) by the end of September 2005 that includes the 2005 research findings and policy options. In addition, an application for a one-year continuation grant of up to \$207,617 has been submitted to the Human Resources and Services Administration (HRSA) to conduct a study of ND's American Indians to determine if there are unique opportunities within this population to decrease the percentage of uninsured. Other proposed grant activities include developing policy options and building consensus around improving access to health care.

It is estimated that nearly 11,000 children in ND are uninsured and approximately 7,000 children are eligible for Medicaid, Healthy Steps or the Caring Program. In late 2002, the Dakota Medical Foundation (DMF), an independent grant making organization that invests in projects designed to improve health and health care access, received a \$700,000 four-year grant from the Robert Wood Johnson Foundation to join the nationwide Covering Kids & Families Initiative. The goal is to connect all eligible children to existing low-cost or free health care coverage programs offered within the state. DMF provided \$577,000 in additional funding and resources to add to the success of the ND Covering Kids & Families project. The Covering Kids and Families project is a comprehensive, outcome-based structure for reducing the number of uninsured children in ND by increasing enrollment in Medicaid, SCHIP and the Caring Program. There are three major components of this proposal: 1) Statewide

Project, 2) Enrollment Assistance Project, and 3) Enrollment Incentive Project.

This four-year ND initiative will enroll children in existing health coverage programs: Medicaid, the State Children's Health Insurance Program (SCHIP) and the Caring Program for Children. These programs offer free or low-cost health care coverage to eligible children. Eligibility is based on family size and household income. Benefits may include primary physician care, hospitalization, drug costs, dental and vision.

The Statewide Covering Kids and Family Advisory Board operates under a proven governance structure to be an effective independent voice for children in need of health care coverage. The ND State Title V Director is a member of this Board.

From January 2003 to March 2005, the number of children enrolled in coverage programs increased by 1,747, a 6% statewide increase. Caring Program enrollment increased from 625 to 685, Healthy Steps, the state children's health insurance program, increased from 2,111 to 2,314, and Medicaid increased from 25,575 to 27,059.

ND Medicaid pays for health services for qualifying families with children, and people who are pregnant, elderly or disabled. Eligibility requirements are at 133% of the Federal poverty level for pregnant women and children to age six. Eligibility requirements are at 100% of the Federal poverty level for children ages 6-19. The number of Medicaid-eligible individuals for the last 12 months ranged from about 52,000 to over 53,000. Approximately 50% of those eligible are under the age of 21, 16% are disabled and 13% are classified as aged. As of March 2005, 27,059 children were enrolled in Medicaid. Currently, there is no asset limit for children, families or pregnant women in the children and families coverage group. Due to an improving economy, ND's Federal Medical Assistance Percent (FMAP) is decreasing. In 2004, the DHS conducted a Medicaid enrollee survey. Results of this study are available at: <http://www.state.nd.us/humanservices/info/pubs/docs/medical-recipientsurvey-results-detailed2004.pdf>

In 2004, 43,893 individuals were eligible for Health Tracks, ND's EPSDT program. Screening ratios in the Health Tracks program increased from 50% in FY 2003 to 60% in FY 2004.

Healthy Steps, ND's State Children's Health Insurance Plan, provides premium-free, comprehensive health coverage to uninsured children up to 19 years old in qualifying families. Eligibility requirements are at 140% of the Federal poverty level. Modest co-payments apply for certain services, which are waived for American Indian children. As of March 2005, 2,314 individuals were eligible for Healthy Steps. Children continue to receive medical, dental and vision benefit coverage. A joint application for Medicaid and Healthy Steps has been available for some time. Recently, Healthy Steps and Medicaid began to use a combined computerized eligibility system. With this change, the state expects to add 600 to 1,000 children to Healthy Steps. A seamless eligibility process for three low cost and free health coverage programs will soon be a reality.

The Caring Program for Children provides free health and dental care for children up to age 19 years old who are not covered by or eligible for Medicaid, other health insurance, or accepted by Healthy Steps. Eligibility requirements are at 200% of the Federal poverty level. As of March 2005, 685 children were enrolled in the Caring Program.

The Medicaid program administers a managed care plan, which is contracted through Noridian. Noridian utilizes the AltruCare Plan for care and care management in Grand Forks, Walsh and Pembina counties. In addition, Medicaid continues to manage the Primary Care Provider Program, which was initially implemented in January 1994. The only other known Health Maintenance Organization (HMO) is Heart of America, which provides services around Rugby ND. This HMO has been in existence for a number of years.

The Community HealthCare Association of the Dakotas works to provide a network for advocacy and support services to member organizations whose purpose is to provide primary health care to the

medically underserved residents of North and South Dakota. ND currently has five Federally Qualified Health Centers with a total of 13 delivery sites.

Coal Country Community Health Center - Beulah, Center and Halliday  
Family HealthCare Center - Fargo (2) and Moorhead  
Migrant Health Services, Inc. - Grafton and Moorhead  
Northland Community Health Center - McClusky, Rolette and Turtle Lake  
Valley Community Health Center - Northwood and Larimore

Unfortunately, the federally qualified health center in Bismarck, ND's capital city, voluntarily surrendered their federal funding as of October 31, 2003. St. Alexius, one of the city's two major medical centers, has convened a Community Taskforce to study the needs of the uninsured and the viability of establishing a federally qualified health center.

The Aberdeen Area American Indian Healthy Start Program continues to receive funding, but Healthy Start Inc. operates only on the Turtle Mountain reservation. ND MCH Programs have had minimal involvement with the Program.

Temporary Assistance for Needy Families (TANF) Program provides a monthly payment on behalf of children who are dependent and deprived of parental support under state law. The monthly case average for the period 7/03 to 3/05 was 2,956.

## **B. AGENCY CAPACITY**

### **CSHCN Program -- Statewide Systems**

The following section describes the state CSHCN program's work to ensure a statewide system of services for children with special health care needs and their families. Relevant content is also included under the CSHCN service section.

State Program Collaboration with Other State Agencies and Private Organizations -- North Dakota (ND) has many strong collaborative partnerships working at the state level. State CSHCN staff currently participates on 39 interagency committees, thus assuring collaboration on a wide range of issues of importance to CSHCNs and their families. One example that helps illustrate some of ND's successful partnerships of which Title V is a part is the Interagency Coordinating Council (ICC). The ICC is a group appointed by the Governor that provides leadership to support improvements in the early intervention system for infants and toddlers with disabilities. This group meets jointly with the Individuals with Disabilities Education Act (IDEA) Advisory Committee. A Memorandum of Understanding concerning cooperation and collaboration in providing services to young children age's birth through five in ND is in effect.

State Support for Communities -- State support for communities is addressed through funding of community-based care coordination programs and multidisciplinary clinics held at various locations throughout the state, partnerships with county social service staff that work with the CSHS program at the local level, and activities to enhance local level data capacity addressed through the SSDI grant. For tables depicting uses of Title V funds at the local level proposed for FY 2006, refer to the following URL: <http://www.ndmch.com/FY06UseOfTitleVFunds.doc>

Coordination with Health Components of Community-based Systems - Multidisciplinary clinics and care coordination activities are the primary mechanisms by which comprehensive health components are successfully coordinated. Many health disciplines participate in team clinics, which provide comprehensive care to CSHCN's and their families. Public health care coordination staff assures coordination between public health programs, private sector health care providers, related service providers in the school setting, etc.

Coordination of Health Services with Other Services at the Community Level - Infrastructure that supports coordination of health and other services at the community level is found in the regional interagency coordinating councils (RICC's), which focus on children birth to three in early intervention. RICCs were formed in all eight regions to advise the ND Interagency Coordinating Council, local early intervention providers, the Regional Developmental Disabilities Program Administrator and Infant Development Coordinator of Early Intervention issues affecting infants and toddlers with developmental delays or disabilities or at-risk for developmental delays and their families. RICCs are charged with developing and monitoring regional early intervention quality improvement plans. RICC membership includes: Parents, Early Head Start, Early Intervention Providers, Protection and Advocacy, Family Support Service Providers, Special Education, Referral Sources, Childcare Providers, Arc, Legislators, and other Early Intervention partners unique to the region. Membership represents the geographic areas and ethnic make-up of the region.

## Statutes and their Impact

The State Health Officer of the ND Department of Health (DoH) is responsible for the administration of programs carried out with allotments made to the state by Title V. The ND Department of Human Services (DHS) administers the portion of funds allotted for children with special health care needs.

The DoH functions in compliance with Chapter 28-32, Administrative Agencies Practice Act, North Dakota Century Code (NDCC). The Divisions of Family Health, Injury Prevention and Control and Nutrition and Physical Activity, within the Community Health Section, have statutory authority to accept and administer funds for the following programs: MCH/Title V, WIC, Family Planning/Title X and Domestic Violence (both state general and marriage license surcharge). The MCH/Title V and Family Planning/Title X are administered within the Division of Family Health. The WIC Program is administered within the Division of Nutrition and Physical Activity. The Domestic Violence Program is administered within the Division of Injury Prevention and Control. The Governor named the DoH the lead agency for the STOP Violence Against Women Program contained in the federal crime bill. The Division of Injury Prevention and Control administers the STOP Program. The NDCC mandates donated dental services (23-01-27), newborn metabolic screening (23-01-03.1 and 25-17- 01 to 25-17-05) and SIDS reporting (11-19.1). All three of these programs are located in the Division of Family Health.

Administrative duties of state and county agencies and confidential birth reports for newborns with visible congenital deformities are addressed in NDCC Chapter 50-10. Provision of medical food and low-protein modified food products by CSHS is addressed in NDCC 25-17-03.

## Preventive and Primary Care Services for Pregnant Women, Mothers and Infants

The Family Planning Program offers education, counseling, exams, lab testing, infertility services and contraceptives. Twenty-one clinical sites, which include two correctional centers, provide services throughout the state. In 2004, services were provided to 15,674 women and men, 74 percent of who were at or below 150% of the federal poverty level.

The Family Planning Program is included as a constituent program represented on the Memorandum of Agreement with the DHS to assure quality and accessible care to improve the health status of children with special health care needs, pregnant women, mothers, infants and children, especially those who are disadvantaged.

The Family Planning Program Director is a member of the Tobacco Partnership, which includes representatives from the Tobacco Program, WIC Program, Optimal Pregnancy Outcome Program and an OB/GYN physician. The goal of this partnership is to strategize avenues to prevent and/or reduce the use of tobacco by women of reproductive age. In addition, she serves as a member of a stakeholders group whose goal is to enhance education regarding risk behaviors related to HIV, STDs, teen pregnancy and unintended pregnancy.

The Family Planning Program receives supplemental funding from Title V to assist in the support of state administrative functions.

The Newborn Metabolic Screening (NBS) Program identifies infants at risk and in need of more definitive testing to diagnose and treat affected newborns. Program objectives include assurance that all infants testing outside of normal limits received prompt and appropriate confirmatory testing, and the development and provision of education to health care providers, families and communities. Currently, 40 conditions/disorders are included in the newborn screening profile. Cystic Fibrosis will be added in early fall of 2005.

ND's testing continues to be performed by the University of Iowa's Hygienic Laboratory in Des Moines. The NBS Program Director provides follow-up services for positive and borderline cases. The NBS Program has an advisory committee that meets quarterly to provide recommendations on such issues as policy/protocol development and proposed conditions/diseases to be screened for. The Advisory Committee membership includes the State Health Officer, the NBS Program Director, the State Title V Director, the State CSHCN's Director, a geneticist, a neonatologist, a pediatric endocrinologist, an OB/GYN nurse educator, a hospital association executive, the Iowa lab director, the Iowa metabolic consultant, pediatricians, family practice physicians, and a parent representative.

The Optimal Pregnancy Outcome Program (OPOP) provides multi-disciplinary teams committed to enhance the prenatal care women receive from their primary health care provider. The team utilizes opportunities to nurture the pregnant woman's self esteem, self-confidence, and reinforce her important role and responsibility in having the healthiest baby possible. The outcome goals for OPOP include increased birth weights, decreased incidence of low weight births, decreased incidence of small for gestation age, pre-term labor prevention/early recognition, decreased occurrence of preventable congenital anomalies, decreased incidence of large for gestational age, reduction of morbidity of pregnancy, enhanced maternal/infant bonding to increase mothers commitment to positive pregnancy outcome, increased breastfeeding to benefit mother and infant, increased availability and access to comprehensive prenatal care services, facilitation of early entry and access into medical prenatal care, and empowerment to make healthy lifestyle choices. Nine sites throughout the state provide OPOP services. In 2004, a total of 546 clients were served through OPOP clinics.

The Maternal/Infant Nurse Consultant is the OPOP Director. She maintains collaboration with the WIC program, the tobacco program, public health and the March of Dimes to implement measures to encourage a term and healthy pregnancy.

The Sudden Infant Death Syndrome Program (SIDS) provides support, education and follow-up to those affected by a sudden infant death. In the belief that every child should live, ND enacted legislation in 1977 that prompted the development of the ND Sudden Infant Death Syndrome (SIDS) Management Program. The SIDS Management Program provides:

- \* a system for reporting suspected SIDS cases to the DoH.
  - \* provision for payment of autopsies.
  - \* support and counseling to families of SIDS victims.
  - \* the use of the term "sudden infant death syndrome" where appropriate on death certificates.
- distribution of information about SIDS to health-care professionals and the concerned public.

The Maternal/Infant Nurse Consultant is the SIDS Program Director. She maintains collaboration with the local SIDS Affiliate, public health and Child Care Resource and Referral (CCRR) to implement and coordinate a safe sleeping environment for infants/children under the age of one.

The Women's Health Program acts as a catalyst to facilitate increased awareness of the importance of women's health through discussion of issues and gaps in service and enhance availability of services through cross referral between programs providing services to women. The Family Planning Program Director serves as the Women's Health State Coordinator. She is a member of the Outreach Committee for the Center for Excellence in Women's Health, whose goal is to facilitate the expansion

of accessible women's health services across ND.

## Preventive and Primary Care Services for Children

Local agencies, including public health agencies, conduct primary preventive health services for the child and adolescent populations.

The Abstinence Education Program promotes the health of youth through abstinence-only education. The overall goal of the program is to provide abstinence across communities of ND and promote the health of youth through abstinence-only education. The program objectives are to 1) reduce teen pregnancy, and sexually transmitted diseases, 2) educate abstinence until marriage by supporting youth with abstinence education programs, and 3) involve parents and the communities in the development of efforts to promote abstinence. Currently, contracts exist with an entity in each of the state's eight regions and one tribal entity. The 59th Legislative Assembly provided direction and spending authority (\$220,000) to the DoH to seek out additional abstinence program funding. A Community-based Abstinence Education Grant was recently submitted for \$488,337.

The Child and Adolescent Health Services Program provides consultation and technical assistance to state and local agencies and school nurses to promote the health of children and adolescents. The program is staffed by a 50 percent nurse consultant (Child and Adolescent Health Coordinator), who represents child and adolescent issues on various committees and workgroups, such as the Asthma State Workgroup and the School Health Interagency Workgroup.

The Coordinated School Health Program provides a framework for schools to use in organizing and managing school health initiatives. The goal of this program is to build state education and health agency partnership and capacity to implement and coordinate school health programs across agencies and within schools. Eleven school districts, representing 30 percent of the student population, have been selected as demonstration sites to implement CSHP. A School Health Interagency Workgroup made up of staff from the Department of Public Instruction, DHS and DoH meets every other month to collaborate and coordinate on issues pertaining to school health. The Title V Director provides the leadership for this program.

The Early Child Comprehensive Systems (ECCS) Program supports collaborations and partnerships that support families and communities in their development of children who are healthy and ready to learn at school entry. The goal of this program is to build early childhood service systems that address access to health insurance and medical home, mental health, early care and education/child care, parent education, and family support. The Healthy North Dakota Early Childhood Alliance is currently working on the development of a state ECCS plan, which is scheduled to be completed by January 1, 2006. The Child and Adolescent Health Coordinator dedicates 50 percent of her time to this program.

The Injury Prevention Program promotes prevention of injuries through projects on seat belts, child passenger safety, bike helmets, home and product safety, poison control, suicide prevention and other injury-specific topics. Program staff provide training, technical assistance, educational materials, and safety products to local entities to implement community-based intervention projects. The program director and health educator are certified child passenger safety instructors, and the director is commissioned with the US Consumer Product Safety Commission to conduct recall effectiveness checks, product injury investigations and other assignments. An injury surveillance system identifies, develops and analyzes data sources to assist in the development of injury intervention initiatives and in the creation of a data based state injury plan.

The Lead Program maintains surveillance of reported childhood blood lead results and provides assistance for follow-up on elevated cases.

The Maternal and Child Health Nutrition Program provides consultation and technical assistance, monitors nutrition data, plans and evaluates nutrition programs, coordinates nutrition related activities, and acts as a clearinghouse for nutrition information and training. The State MCH Nutrition Services

Director is 100 percent funded through Title V. In addition, there are 17 nutritionists working in local public health agencies throughout the state that are in part funded through Title V. The State MCH Nutrition Services Director and many of the local public health nutritionists participate in the Healthy Weight Council and the Healthy North Dakota Breastfeeding Committee, Healthy School Nutrition Committee and the Fruit and Vegetable Committee. All of these committees are working on issues directed toward healthy weight for children and adolescents through the promotion of increased fruit and vegetable intake (5-A-Day) and increased physical activity.

The Oral Health Program provides prevention education, screening and consultation and administers school fluoride programs. Program staff collaborate with public and private groups to assure policy/program development with an emphasis on improving access to oral health care. The program supports the maintenance of school-based fluoride and sealant programs and provides support for oral health outreach services at public health clinics. Six Title V funded regional dental health consultants provide training, technical assistance and consultation to local agencies to build capacity for oral health needs assessment and health promotion and prevention efforts. These efforts focus on maintaining school-based fluoride programs; promoting use of dental sealants; and providing dental health education for mothers and children with an emphasis on the prevention of early childhood caries, orofacial injuries, and tobacco use.

In 2002, ND received a Centers for Disease Control and Prevention Cooperative Agreement State-Based Oral Disease Prevention Program grant for developing capacity and infrastructure of the state oral health program. The ND Oral Health coalition was formed in 2004 and is working on the development of a state oral health plan, which is scheduled to be completed by August 2005. In 2003, ND received a HRSA State Oral Health Collaborative Systems grant for integrating oral health with other programs within the state and to leverage resources in mutual support of oral health activities. The goals of this grant are to incorporate a service learning opportunity for dental students at the University of Minnesota for a rotation at the Bridging the Dental Gap Clinic and to provide fluoride varnish training to non-dental providers that would assure delivery of care to the most vulnerable populations in the state. The third grade Oral Health Basic Screening Survey was completed in May 2005. Regional oral health consultants partnered with local public health nutritionists to add height and weight data to the survey.

#### Services for CSHCN

a. To provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI (SSI)

ND is a 209(b) state, which means SSI beneficiaries under 16 years of age are not automatically eligible for Medicaid. If assets are an issue affecting Medicaid eligibility, children eligible for SSI can also be covered under the children and family coverage groups where asset testing is not considered.

To monitor the status of the SSI population in the state, each year the state CSHCN program runs a special report on children receiving SSI and their Medicaid status. See Section III.F, Health Systems Capacity Indicator #08, for more information.

An interagency agreement is in place between Disability Determination Services (DDS) and CSHS to assure SSI recipients and cessations receive information about program benefits or services. State CSHCN staff conduct a variety of outreach activities related to the SSI program, including a mailing to families notifying them about programs that could be of assistance that provides contact information if further support is needed. Annually, state CSHCN staff convenes a meeting between DDS, the local Social Security Administration office, Medicaid, and key family organizations in the state to assure communication about any new developments that have occurred or that are expected during the year.

b. To provide and promote family-centered, community-based, coordinated care including care coordination services

Efforts to enhance family-centered care include support of a CSHS Family Advisory Council that assures family involvement in policy, program development, professional education, and delivery of care; service contracts with two family organizations in the state that provide emotional support, information, and training for families; active state CSHCN staff involvement with other related family support initiatives occurring in the state (e.g.) advisory board participation, family conference planning committees, etc.; and annual telephone assessment of family satisfaction with CSHS services, which is monitored through the department's state strategic planning process.

The following section describes programs administered by the State CSHCN program in ND.

The Care Coordination Program provides community-based case management services for CSHCN's to help families' access services and resources in their community, and when needed, across multiple service delivery settings. Public health nurses provide care coordination services to a broad population of children with physical, developmental, behavioral or emotional conditions in five eastern counties of the state. County social service staff in all 53 counties of the state provides care coordination services for children eligible for treatment services through CSHS. State-level staff provides technical assistance, training, and quality assurance activities to support these local programs.

The Data Systems Development Program provides data on the health status of CSHCN's in order to provide evidence-based decisions for program development and service delivery. Major activities include State Systems Development Initiative (SSDI) grant administration, birth defects monitoring, needs assessment, performance and outcome monitoring, estimates of chronic disease prevalence, utilization and cost, and data-related publications.

The Information Resource Center provides public information services to families and service providers in order to increase access to health care information and resources. The CSHS Unit operates an information resource center that provides public information services free of charge.

The Metabolic Food Program is mandated to provide medical food and low-protein modified food products to certain individuals with PKU and MSUD in order to increase access to necessary dietary treatment therapies. Males under age 22 and females under age 45 receive formula at no cost while others outside those age groups can receive formula at cost. Low protein modified food products are also provided at no cost to males under age 22 and females under age 45 who are receiving medical assistance when its determined medically necessary. State-level CSHCN staff develop policies and procedures that guide the program, maintain the on-site inventory, fill client orders upon request, and provide a variety of state-level care coordination services.

The Multidisciplinary Clinic Program provides coordinated management of various chronic pediatric health conditions that are best addressed using a comprehensive, team approach. CSHS directly administers or sponsors clinics for the following 10 conditions: Cleft Lip and Palate, Scoliosis, Cardiac, Metabolic Disorders, Cerebral Palsy, Developmental Assessment, Myelodysplasia, Diabetes, Neurorehab, and Asthma. State CSHCN nursing staff coordinates some of the clinics held each year while others are provided through contracts with health systems, hospital foundations, universities, or other not-for-profit entities. For the latter, state CSHCN staff provide technical assistance, conduct quality assurance activities, and convene an annual meeting for clinic coordinator staff from across the state to assure communication about any new developments that have occurred or that are expected during the year. A network of public and private health care providers across the state participate in the multidisciplinary clinic program, including local county social workers affiliated with CSHS who staff some of the clinics. Clinics provide a secondary benefit as an avenue for pre-service training in the state, particularly for nursing and speech/language students.

The Russell-Silver Syndrome Program is mandates payment for medical food and services related to growth hormone treatment for individuals with Russell-Silver Syndrome through age 18. The 2005 Legislature created this new program and required that services be provided at no cost regardless of income. Care is limited to \$50,000 per child each biennium.

The Specialty Care Program helps families pay for specialty care diagnostic and treatment services. Families apply for services at their county social service office. County staff determine financial eligibility if it is required. Income eligibility is mandated at 185 percent of the federal poverty level for treatment services through CSHS. Assets are not considered. The CSHS Medical Director determines medical eligibility at the central office based on a list of eligible medical conditions, which is developed with the help of the CSHS Medical Advisory Council. Other state-level CSHCN staff develop policy and procedures, provide technical assistance in the application process, conduct training for county social service staff, process claims payments for eligible children using the Medicaid Management Information System, and coordinate benefits between third party payers. The unit also maintains a list of qualified health care providers who have been approved to participate in the program.

CSHS Administration provides leadership and support to state and local partners to implement health service system improvements. CSHS works with others in planning and policy development to address identified needs of CSHCN and their families. Primary partners include families, county social service staff, health care providers and related program administrators. State-level CSHCN staff participate on a number of committees, advisory boards, and task forces and work on a variety of special projects to improve children's health. Examples of special projects include:

1) First Sounds - ND's Early Hearing Detection and Intervention Program is administered by the ND Center for Person's with Disabilities at Minot State University. A CSHS staff member is part of the grants management team. Through this project, significant gains have been made in the percent of newborns that have had their hearing screened before hospital discharge. Future efforts will continue to focus on early hearing detection and intervention as well as tracking, surveillance, and integration activities.

2) The State Asthma Workgroup -- This workgroup is an informal collaboration of stakeholders, program representatives, and organizations inside and outside of state government whose membership shares the goals of enhanced asthma surveillance, education, direct services, and partnerships. Despite limited resources, this group has achieved significant results, including: development of a ND Asthma Action Plan and Physician Desk Guide, development of web-based provider training on clinical practice guidelines, funding for children's asthma clinics, enhanced data surveillance capabilities through the Behavioral Risk Factor Surveillance System (BRFSS), and successful legislation relating to student's possession and self-administration of medication for the treatment of asthma and anaphylaxis.

3) National CSHCN Objectives have been addressed, in part, through team efforts funded by a Medical home CATCH grant. The ND CATCH team is comprised of a pediatrician, CSHCN staff, representatives from two family organizations, and a representative from a major health system known for its services to CSHCN's. Work efforts to date have focused on assessment and community planning activities in support of medical home implementation. CSHS staff also participates on an Early Childhood Comprehensive Systems subcommittee that addresses access to health care/medical home. Transition is addressed through participation on a Transition Steering Council lead by the Department of Public Instruction. Future transition efforts will hopefully be supported through the Champions for Progress Center state team meeting and incentive award, if a proposal that has been submitted by ND is funded.

### Culturally Competent Care

Our society is becoming more diverse and often this trend is associated with widening health disparities among culturally diverse groups. Given this development, communication interventions that affect health behavior are increasingly important strategies for improving the health of people. In a response to this issue, Dr. Terry Dwelle, State Health Officer, has developed a Culturally Responsive Communication course. This course is intended to develop and expand the skills of public health professionals in designing and delivering culturally responsive health communication. Dr. Dwelle has been presenting this course over the last year to DoH staff.

The DoH and the Indian Affairs Commission, along with tribal leaders through the state, have formed the Tribal State Health Care Task Force in an ongoing effort to address the health care needs of American Indians.

The State Health Disparities Work Group exists to provide leadership in identifying and positively impacting disparities affecting ND citizens. The workgroups vision is "Health equity for all North Dakotans." Health disparities in ND are defined as inequalities in health status, utilization, or access due to structural, financial, personal, or cultural barriers. Population categories affected include, but are not limited to, those identified by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation.

Efforts to enhance culturally competent care include participation on the DHS Cultural Awareness Committee. This committee strives to enhance the delivery of human services to the state's increasingly diverse population. Past activities have focused on the American Indian population and included development of a cultural guidebook, staff training and meetings with tribal program staff to enhance communication and collaboration. The DHS has a wonderful resource in its Tribal Liaison. This position was created in 1997 to enhance working relationships and communication between tribal programs and the department. Title V advisory councils also include members that represent major cultural groups in the state.

## **C. ORGANIZATIONAL STRUCTURE**

The North Dakota Department of Health (DoH) employs about 300 people dedicated to making North Dakota a healthier place to live. The five sections of the department include: 1) Administrative Support, 2) Medical Services, 3) Community Health, 4) Health Resources, 5) Environmental Health, and 6) Emergency Preparedness and Response. Employees in these sections provide public health services that benefit the citizens of North Dakota.

The DoH is dedicated to ensuring that North Dakota is a healthy place to live and that each person has an equal opportunity to enjoy good health. The DoH is committed to the promotion of healthy lifestyles, the protection and enhancement of health and the environment, and the provision of quality health-care services for the people of North Dakota. The DoH advances its mission by networking, facilitating local efforts, collaborating with partners and stakeholders, and providing expertise in developing creative public health solutions.

Terry Dwelle, M.D., State Health Officer, is responsible for the administration of programs carried out with allotments made to the state by Title V. The governor appoints the Health Officer. A State Health Council serves as the DoH's advisory body. The council's 11 members are appointed by the governor for three-year terms. Four members are appointed from the health-care provider community, five from the public sector, one from the energy industry and one from the manufacturing and processing industry.

The organizational chart for the North Dakota Department of Health can be accessed at the following URL: <http://www.health.state.nd.us/ndhd/contact.htm>

The Family Health Division, within the Community Health Section of the DoH, is the lead division for administration of the Title V funds. The Community Health Section's mission is to improve the health of North Dakota citizens by working actively to promote the choice of healthy behaviors and to prevent disease and injury. The section is responsible for coordination of public health education and intervention activities such as wellness promotion and health-risk reduction, promotion of optimal nutrition, reduction of tobacco use, injury prevention and improvements in dental health. Many of the services are provided through local public health units.

There are six divisions within the Community Health Section: 1) Cancer Prevention and Control, 2) Chronic Disease, 3) Family Health, 4) Injury Prevention and Control, 5) Nutrition and Physical Activity,

and 6) Tobacco Prevention and Control. Three of these six divisions receive funds from the Title V grant. These include Family Health (Title V leadership), Injury Prevention and Control, and Nutrition and Physical Activity.

The organizational chart for the Community Health Section can be accessed at the following URL: <http://www.ndmch.com/MCHOrganizationalChart.pdf>

North Dakota's public health system is made up of 28 single- and multi-county local public health units (LPHUs). LPHUs are autonomous and not part of the DoH. Their relationship is cooperative and contractual. Services offered by each public health unit vary, but all health units provide services in the areas of maternal and child health, health promotion and education, and disease prevention and control. Some local public health units maintain environmental health programs; others partner with the North Dakota Department of Health to provide environmental services such as public water system inspections, nuisance and hazard abatement and food service inspections. Local public health activities are financed by a combination of mill levy funding and/or city or county general funds, state aid and federal funding. A state map for each LPHU can be accessed at the following URL: <http://www.health.state.nd.us/localhd/>

The ND Department of Human Services (DHS) administers the portion of funds allotted for children with special health care needs. The DHS mission is to provide quality, efficient, and effective human services, which improves the lives of people. The Governor appoints the Executive Director of the DHS, a large umbrella agency that is currently headed by Carol K. Olson. DHS is organized into three major subdivisions consisting of Field Services, Program and Policy Management, and Managerial Support. DHS, through the Children's Special Health Services (CSHS) Unit, administers the portion of funds allotted for children with special health care needs. CSHS is located along with Medicaid and SCHIP in the Medical Services Division in the Program and Policy Management subdivision. The CSHS mission is to provide services for children with special health care needs and their families and promote family-centered, community-based, coordinated services and systems of health care.

The administrative arm of the department receives and distributes funds for human service needs, provides direction and technical assistance, sets standards, conducts training of county staff, manages the computerized eligibility systems, and provides program supervision to county employees.

Direct services are provided through the Developmental Center and the State Hospital in addition to regional Child Support Enforcement Units and Human Service Centers (HSCs). Each of the eight HSC's serves a designated multi-county area and provides an array of services such as Developmental Disabilities, Vocational Rehabilitation, Child Welfare, Children's Mental Health, etc.

The following organizational charts can be found in the attached Word document: 1) North Dakota Department of Human Services, and 2) North Dakota Medical Services Division.

Delivery of human services also involves a partnership with 53 county social service offices. In the DHS, county social service offices work cooperatively with the state agency in administering programs. County social services are important local service providers and are often the first point of contact for families. Each county social service office has a designated staff member that provides services for CSHCNs and their families served by CSHS. A state map and contact information for each county social service office can be accessed at the following URL: <http://www.state.nd.us/humanservices/locations/countysocialserv/index.html>

The DoH and DHS mesh in a variety of ways, both formal and informal, through the Title V programs. Examples include: quarterly meetings held for the divisions of Family Health, Injury Prevention and Control, Nutrition and Physical Activity and CSHS staff; representation of the State Health Officer on the CSHS Medical Advisory Council; representation from the Family Health Division on the CSHS Family Advisory Council; and other committees or workgroups that utilize representation from both departments to work on issues held in common.

Through a contractual agreement with the DoH and DHS, the State Systems Development Initiative (SSDI) works to build capacity to access and use data in MCH planning. The FTE for the SSDI coordinator is located in the DHS CSHS Unit, but serves both departments.

The following organizational chart can be found in the attached Word document: State of North Dakota Title V.

See Section III B, Agency Capacity for more information on programs funded by the Federal-State Block Grant Partnership.

## **D. OTHER MCH CAPACITY**

Terry Dwelle, M.D., State Health Officer, is responsible for the administration of programs carried out with allotments made to the state by Title V. The state health officer is appointed by the governor to be the chief administrative officer of the department as well as a member of the governor's cabinet. The state health officer implements state laws governing the department within the guidance of the governor and the regulations adopted by the State Health Council. In addition, the state health officer is a statutory member of about a dozen boards and commissions. Governor John Hoeven appointed Terry Dwelle, M.D., to the Office of State Health Officer in October 2001. Dr. Dwelle earned his medical degree from St. Louis University School of Medicine. He later received a master's degree in public health and tropical medicine from Tulane University. Dr. Dwelle has worked with the University of North Dakota School of Medicine, the Centers for Disease Control and Prevention and the Indian Health Service.

The deputy state health officer, Arvy Smith, assists the state health officer in implementing state laws governing the department and serves on several boards and commissions in lieu of the state health officer. In addition, the deputy state health officer provides leadership in administrative and support functions for the department. Ms. Smith was appointed as the Deputy Health Officer in October 2001. She is a certified public accountant and a certified manager who has 24 years experience in state government. Ms. Smith has completed coursework towards and continues to pursue a master's degree in public administration with a health care certificate.

The Division of Family Health, within the Community Health Section (CHS) of the DoH, is the lead division for administration of the Title V funds. There are six divisions within the CHS: 1) Cancer Prevention and Control, 2) Chronic Disease, 3) Family Health, 4) Injury Prevention and Control, 5) Nutrition and Physical Activity, and 6) Tobacco Prevention and Control. Three of these six divisions receive funds from the Title V grant. These include Family Health (Title V leadership), Injury Prevention and Control, and Nutrition and Physical Activity. Senior level staff within these three divisions include:

**Family Health:** Kim Senn is the Director for the Division of Family Health. Kim joined the DoH in 2000 as a nurse consultant and became Director of the Division of Family Health in September 2003. Kim earned a bachelor's degree in nursing from Medcenter One College of Nursing. Kim has twenty-one years experience in health care, including acute care, management and public health.

**Injury Prevention and Control:** Mary Dasovick is the Director for the Division of Injury Prevention and Control. Mary joined the DoH in 1994 as a nurse consultant and became Director of the Division of Injury Prevention and Control in September 2003. She graduated from the University of Mary with a bachelor's degree in nursing. Mary has worked as a public health, geriatric and forensic nurse.

**Nutrition and Physical Activity:** Colleen Pearce is the Director for the Division of Nutrition and Physical Activity. Colleen joined the DoH in 1978 and has worked as the program director of the Special Supplemental Nutrition Program for Women, Infants and Children since 1979. She became the

Director of the Division of Nutrition and Physical Activity in September 2003. Colleen earned a bachelor's degree in food and nutrition from ND State University and a master's degree in public health from the University of Minnesota.

Until May 31, 2005, Dr. John Joyce served as the Section Chief for the CHS. As of June 1, 2005, the CHS initiated a Leadership Team concept where by the six division directors within the CHS serve as the section lead on a two-month rotation system. Dr. Joyce will continue to serve as a Medical Consultant for the CHS. Dr. Joyce graduated from the University of ND School of Medicine and Health Sciences. He has been affiliated with the West River Medical Center in Hettinger since 1981, where he is a family practice physician. He completed his Masters in Public Health through the University of Wisconsin in 2004.

The CHS has access to a wide range of administrative support personnel within the DoH. Administrative support includes Accounting, Human Resources, Information Technology, Vital Records, Education Technology, Public Information, and Local Public Health. A finance liaison, housed in the Accounting Division, is specifically assigned to work with the Title V grant.

Healthy North Dakota is a statewide initiative whose goal is to improve the health of every North Dakotan by inspiring people to establish personal behaviors and support policies that improve health and reduce the burden of health care costs. Title V programs work closely with Healthy North Dakota priorities and initiatives. Melissa Olson was named director of Healthy North Dakota in 2003. She has bachelor's degrees in food and nutrition and corporate and community fitness from ND State University. Melissa has worked in state government since 2000, managing both the school health and tobacco programs.

Stephen Pickard, M.D., is a CDC epidemiologist assigned to ND. Dr. Pickard has 13 years of experience assisting state health departments as a CDC employee. He was assigned to the DoH in 2001 where he acts as the senior consulting epidemiologist for the department. Dr. Pickard's areas of expertise are in epidemiologic capacity building, state surveillance systems, and community health. He co-facilitates the Healthy North Dakota workgroup on community engagement, administers the Behavioral Risk Factor Surveillance System, and is the epidemiologic consultant to the Youth Risk Behavior Survey.

Below is a summary of staff that work on Title V programs:

DoH Divisions/Staff funded and not funded by Title V

Family Health (funded)

Director 0.1 BNSc (Title V)

Nurse Consultants 2.5 BSN's (Maternal/Infant, Child/Adolescent, Newborn Screening)

Dental Hygienists 1.0 RDH (Program director and two out-stationed)

Support Staff 2.5 (Admin Assistant III, Admin Assistant I, student and permanent temp)

Data Processing Coordinator 0.8 BS Computer Science

\* Total Funded by Title V 6.9

Family Health (not funded)

Director 0.9 BNSc (CSHP)

Nurse Consultants 1.5 BSN (Abstinence, ECCS, Title X)

Dental Hygienist 1.75 RDH (CDC, HRSA - Program Director and five out-stationed)

Family Planning/Women's Health 1.0 MBA (Title X)

Support Staff 0.7 (Title X, CSHP - Admin Assistant I and Permanent Temp)

\* Total Not Funded by Title V 5.85

Injury Prevention and Control (funded)

Program Admin 1.0 BS Business Admin

Health Educator 1.0 BA Health

Support Staff 1.0 (Admin Assistant I)

\* Total Funded by Title V 3.0

Injury Prevention and Control (not funded)

Director 1.0 BSN (STOP and FVPS)

Program Admin 1.0 BA Business Admin (CDC, HRSA)

\* Total Not Funded by Title V 2.0

Nutrition and Physical Activity (funded)

Director 0.1 MPH, LN

Nutritionist 1.0 LRD

\* Total Funded by Title V 1.1

Nutrition and Physical Activity (not funded)

Director 0.9 MPH, LN (WIC)

Nutritionist 2.0 LRD (WIC)

Support Staff 1.0 Office Assistant II (WIC)

\* Total Not Funded by Title V 3.9

Carol K. Olson is the Executive Director of ND's largest agency, the Department of Human Services (DHS). Olson has worked in state government in various legislative and executive branch positions for over 20 years. She holds the distinction of being the first woman to serve as chief of staff in the ND governor's office, as well as the first woman to serve as executive director of the DHS. She has a bachelor's degree in criminal justice and has completed course work toward a master's degree in public administration.

CSHS has access to a wide range of managerial and executive support personnel within the DHS. Managerial support includes the Human Resources Division, which contains the Office of Applied Research, the Information Technology Division, and the Legal Advisory Unit. Executive support staff includes a Tribal Liaison and Public Information Specialist. A finance liaison, housed in Fiscal Administration, is specifically assigned to work with the CSHS program.

Since the last grant application was submitted, there have been several changes in the DHS Senior Management team that reports directly to the Executive Director of DHS. JoAnne Hoesel now heads the Mental Health/Substance Abuse Division previously led by Karen Larson. JoAnne had previously worked in the area of children's mental health. The position of Disability Services Division Director, held for many years by Gene Hysjulien, is currently vacant.

David J. Zentner has been Director of the Medical Services Division since 1993. His responsibilities include oversight of the Medicaid Program, the State Children's Health Insurance Program and Children's Special Health Services (CSHS). Mr. Zentner is part of the Senior Management Team that reports directly to the Executive Director of the DHS. In 1969, he graduated from the University of ND with a degree in Business Administration with an emphasis in accounting. Mr. Zentner plans to retire August 2005.

Staff members within the greater Medical Services Division are also available to CSHS on a consultative basis and have proven to be a helpful resource to state CSHCN staff. Included are medical and dental consultants, a coding specialist, a pharmacist, claims payment personnel, prior authorization nurses, a managed care administrator, and various eligibility and policy staff.

Parents of special needs children have not been hired within CSHS. However, the Unit does support a nine-member Family Advisory Council that meets on a quarterly basis. Members are reimbursed mileage, meals and lodging and are paid a \$75.00 consultation fee for each quarterly meeting they attend. The CSHS Family Advisory Council assures family involvement in policy, program development, professional education, and delivery of family-centered care.

Tamara Gallup-Millner, RN, MPA became the CSHS Unit Director July 2001. Professional experiences include four years as a hospital staff nurse and over 20 years of experience within state government, including prior positions as Assistant Clinical Supervisor and Deputy Director within the CSHS unit. Tammy is a member of several professional organizations and serves on many committees, advisory boards and task forces.

CSHS contracts for the services of a part-time Medical Director, Dr. Robert Wentz, who is a pediatrician. In addition to his medical degree, Dr. Wentz received a graduate degree in Public Health from the University of California in 1980. Previously, Dr. Wentz worked in the DoH as MCH Director, Section Chief and State Health Officer. He became CSHS Medical Director in September 1999. CSHS also benefits from a Medical Advisory Council that meets on an annual basis.

The State Systems Development Initiative (SSDI) Coordinator is currently housed in CSHS although the position serves to enhance Title V data capacity for the entire MCH population. Terry Bohn resigned as SSDI Coordinator May 2005.

The CSHS Unit maintains eight full-time staff, seven of which are funded by the MCH Block Grant. Currently, all unit staff are centrally located in Bismarck, ND.

CSHS Staff (funded)  
Unit Director 1.0 MPA (RN)  
Administrators 2.0 BNSC and HSPA I  
Nurse 1.0 BSN  
Support Staff 3.0 Admin Assist I & Office Assist III  
\* Total Funded by Title V 7.0

CSHS Staff (not funded)  
SSDI Coordinator 1.0 Vacant since 5/27/05  
\*Total Not Funded by Title V 1.0

## **E. STATE AGENCY COORDINATION**

ND has a long history of interagency coordination and collaboration. MCH program staff work with other state agency staff on a daily basis through numerous coalitions, task forces, advisory groups, committees and cooperative agreements.

### **Organizational Relationships Among the State Human Services Agencies**

#### **Public Health**

MCH program staff work closely with the state local health liaison, whom acts as the liaison between the ND DoH and local public health units and other key public and private partners. In addition, the public health liaison assists in the facilitation of the quarterly local public health administrators' and director of nursing meetings. MCH program staff attends these quarterly meetings to solicit program input and to provide program updates.

The state MCH Maternal/Infant Nurse Consultant works with local public health staff on a monthly basis to continually update the Child Health Services Manual. This manual provides guidance to local public health agencies on such topics as immunizations, pediatric assessment, anticipatory guidance, newborn home visiting, etc.

#### **Mental Health**

The Mental Health/Substance Abuse Division Director is part of the DHS Senior Management team. The administrator for children's mental health services participated in the fall Title V planning retreat.

The Children's Mental Health System of Care in ND provides therapeutic and supportive services to children with serious emotional disturbance and their families so they can manage their illness and live in the community in the least restrictive setting. Mental health and social emotional development is also one of the components collaboratively addressed through the state's Early Childhood Comprehensive Systems Grant Program. In addition, mental health/substance abuse was identified as a Healthy North Dakota (HND) priority. A HND committee has been formed to address mental health/substance abuse issues in the state.

## Social Services/Child Welfare

County social service offices are often the first point of contact for families who need economic assistance, child welfare services, supportive services for elderly and disabled individuals, children's special health services, or help locating other local resources and programs. DHS divisions have oversight responsibility for County Social Service programs.

The Children and Family Division Director is part of the DHS Senior Management team. Programs in that division include: adoption, early childhood services, the child protection program, children's mental health services, family preservation services, foster care services, the head start state collaboration project, and refugee services. Program administrators housed within the Children and Family Division participated in the fall Title V planning retreat.

## Education

Title V and the Department of Public Instruction (DPI) have a strong partnership and work collaboratively on many projects.

The CSHS Director is a member of the state Interagency Coordinating Council, which meets jointly with the DPI Individuals with Disabilities Education Act advisory group on a quarterly basis to better coordinate services for young children with disabilities.

ND received the Coordinated School Health Programs (CSHP) and Reduction of Chronic Diseases Infrastructure Agreement from CDC in March 2003. Please refer to Section B., Agency Capacity.

The State Asthma Workgroup, with its broad-based membership from the public and private sectors, has been influential and productive in its efforts to increase asthma awareness and education in the state. Please refer to Section B., Agency Capacity.

The ND Center for Persons with Disabilities, at Minot State University, is working with the DoH, DHS, DPI, school nurses and school personnel on the development of a School Health Service Guideline Manual. Targeted for completion by March 2006, this manual will include preventative services, educational services, emergency care, screening recommendations, referrals, and management of acute and chronic health conditions.

The ND DoH and DPI work together to administer the Youth Risk Behavior Survey (YRBS), Youth Tobacco Survey (YTS) and Profiles. The primary staffing source and lead role for the YRBS and Profiles is DPI. The DoH's epidemiologist serves in an advisory role and provides technical assistance for the surveys.

In an effort to enhance education regarding risk behaviors related to HIV, STDs, teen pregnancy and unintended pregnancy, a key stakeholders group has been formed consisting of representatives from the adolescent health, HIV, STD, family planning, and abstinence education-only programs.

## Medicaid

The state Medicaid program is co-located with SCHIP and CSHS in the Medical Services Division within DHS. The Division Director is part of the DHS Senior Management team. The state CSHCN

program has close ties to Medicaid and participates regularly in scheduled meetings to discuss administrative, claims policy, claims payment, and MMIS issues. In addition, a cooperative agreement to assure care and improve health status is in place between DHS, DoH, the Primary Care Office, and the Primary Care Association.

## SCHIP

In October 2002, Dakota Medical Foundation received a \$700,000 grant from The Robert Wood Johnson Foundation. Since January 2003, ND Covering Kids and Families (CKF) has collaborated with state and local agencies from across the state to help families learn and apply for existing low-cost/free health coverage, including Healthy Steps (ND SCHIP), Caring for Children Program and Medicaid. Through a statewide partnership including Dakota Medical Foundation, the ND Insurance Department, ND DHS, ND DoH, Cass County Social Services and Blue Cross Blue Shield's Caring Program for Children, are initiating the effort to conduct outreach, simplify and coordinate the children's health insurance programs. These efforts are enhanced by the endorsement of the Office of the Governor and involvement of ND legislators, county social service departments, business representatives, school districts, insurance agents, community health centers, hospitals, clinics, daycare centers, churches, service clubs and citizen volunteers.

## Social Security Administration/Disability Determination Services

Annually, the State CSHCN program convenes a meeting between Disability Determination Services (DDS), the local Social Security Administration office, Medicaid and key family organizations in the state to assure communication about any new developments that have occurred or that are expected during the year that might affect SSI eligible children. An interagency agreement is in place between DDS and CSHS to assure SSI recipients and cessations receive information about program benefits or services. DDS is located in the Disability Services Division. The Division Director is part of the DHS Senior Management team.

## Vocational Rehabilitation

Vocational Rehabilitation is co-located with Developmental Disabilities in the Disability Services Division. The Disability Services Division Director is part of the DHS Senior Management team. Title V interacts with Vocational Rehabilitation through membership on the Transition Steering Council, a group that focuses on transition services for students with disabilities.

## Alcohol and Substance Abuse

The ND Fetal Alcohol Syndrome Taskforce has a broad membership that works to identify initiatives and possible partnerships to minimize duplication for the prevention and treatment of FAS/FAE in ND. The MCH Newborn Screening Program Director, Maternal/Infant Nurse Consultant and SSDI Coordinator serve on the taskforce. The ND Fetal Alcohol Syndrome Taskforce is a partner of the Four-state Fetal Alcohol Syndrome Consortium. Key objectives of this Consortium include: 1) development of an information base to systematize data collection on prevalence and FAS/FAE to determine high-risk areas and populations, and 2) implement and test an universal, selective and indicated scientifically defensible prevention intervention in high risk areas and populations to see how effective it is in preventing, reducing and/or delaying substance use in order to reduce the rates of FAS/FAE.

The Mental Health/Substance Abuse Division within the ND DHS collaborates with several MCH programs. The Community Coordinator for the Mental Health/Substance Abuse Division participated in the fall 2004 Title V planning retreat. She also participates in planning the Roughrider Health Promotion annual coordinated school health conference. In addition, funding is provided to support mental health and substance abuse community prevention training sessions. The Roughrider Conference is the largest health and wellness education conference in the state, reaching over 375 educators and community members.

## Relationship of State and Local Public Health Agencies

### Federally Qualified Health Centers

Please refer to Section A., Overview of the State.

### Primary Care Association

The ND Deputy Director for the Community Healthcare Association of the Dakotas is an active member of the Community Health Section Advisory Committee. This advisory committee meets on a quarterly basis and receives MCH program updates and provides input into program activities. In addition, the Deputy Director, along with the directors for Title V and CSHS, participate in the quarterly HRSA partnership conference calls.

### Tertiary Care Facilities

There are four major health systems in the state that serve CSHCN's and their families. The most prominent is located in the southeast quadrant and includes a children's hospital. Many of the pediatric subspecialty physicians practice in that same community.

Several physicians participate on committees that have been formed to address Title V priorities. Examples include newborn screening, obesity, etc. The CSHS Medical Advisory Council includes representation of various specialists serving CSHCN's and their families from health systems across the state.

### Technical Resources

Title V programs have benefited from the technical resources of the ND Center for Persons with Disabilities (NDCPD) through Minot State University. First Sounds, ND's early hearing, detection, and intervention program is housed at NDCPD. A cooperative agreement is in place between CSHS and the NDCPD that guides detection, intervention, tracking, surveillance, and integration activities. DoH contracts with the NDCPD for the development of school health guidelines and DHS contracts with the NDCPD to provide a multidisciplinary clinic for children with disabilities.

The state CSHCN program and some of the state's universities have developed a mutually beneficial relationship that involves multidisciplinary clinics for CSHCN. These services are often used as a means of pre-service training for nursing, speech, audiology, and medical students. The state CSHCN program also benefits from the expertise of faculty who participate as clinic team members.

The Title V Director serves on the MCH Advisory Committee for the Center for Leadership Education in Maternal and Child Public Health at the University of Minnesota's School of Public Health. This advisory committee meets to discuss the master's of public health training program, continuing education events and outreach activities to the upper Midwest. One of their major outreach efforts, Healthy Generations (a nationally distributed newsletter), recently contained an article regarding the HND Healthy Weight Council's position paper on assessing heights and weights in school. The Title V Director also participates in the quarterly Rocky Mountain Public Health Education Consortium conference calls.

The Center for Rural Health at the University of North Dakota (UND) identifies and researches rural health issues, analyzes health policy, strengthens local capabilities, develops community-based alternatives, and advocates for rural concerns. Partnerships with Title V programs and other related programs have resulted in valuable resources/publications such as ND Health Professions: Dentists, Traumatic Brain Injury, and Health Care Access in ND: Characteristics of the Uninsured. The Center for Health Promotion and Translation Research at UND provides evaluation for the coordinated school health program.

Following is a report entitled 2003 North Dakota Rural Health Dialogues Summary. This report provides information about health priorities among rural populations that were identified fall 2003. <http://medicine.nodak.edu/crh/publications/dialogue.pdf>

## Plan for Title V Coordination

### Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

Located in the ND DHS, the EPSDT Coordinator participated in the fall 2004 Title V planning retreat. In addition, she participates in numerous Title V program workgroups/coalitions such as the Early Childhood Comprehensive Systems Workgroup, the Oral Health Coalition and the Claims Policy meetings within the DHS Medical Services Division. EPSDT holds annual trainings and contacts the Title V Director prior to the training for content input. This year, a combined local CSHS and EPSDT training is planned. She also provides input and updates to the EPSDT section of the MCH Children's Health Services Manual.

### Other Federal Grant Programs

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) provides healthy foods for proper growth and development, education on choosing healthier ways of eating and referrals to other needed services. WIC is for eligible pregnant, breastfeeding and postpartum women, infants, and children under five years and is available in all counties in ND. An average of 13,500 mothers and children are seen each month in over 75 WIC clinic sites across the state.

WIC has an agreement with the Commodity Supplemental Food Program within the ND Department of Public Instruction. In an effort to assure quality and accessible care, the agreement identifies individuals who are not being served by either program and formalizes and strengthens relationships between programs; thus by reducing duplication, increasing accessibility and providing mechanisms for enhanced program coordination. State and local WIC staff work closely with several of the MCH programs and HND Committees to further nutrition and/or physical activity related issues.

The state CSHCN program works most closely with the Developmental Disabilities Unit in the area of early intervention. State CSHCN staff participates on the state Interagency Coordinating Council (ICC), a group appointed by the Governor to provide leadership to support improvements in the early intervention system for infants and toddlers with disabilities. Regional ICC's have also been created in eight regions of the state. A Memorandum of Understanding is in place that addresses collaboration in providing services to young children birth through age five.

Title V also works collaboratively with Developmental Disabilities and other DoH programs to implement the Birth Review Program. This program provides new parents with information on normal growth and development and helps them identify whether possible risk factors are present that may affect their child's development. Concerned parents receive additional information upon request and are linked to various ND service agencies.

A new area of coordination between the state CSHCN program and the Developmental Disabilities Unit is the joint leadership of a Medical Needs Task Force. This informal group recently began meeting to address children with extraordinary medical needs and will likely integrate planning and policy recommendations in conjunction with interim legislative child health study findings.

The Family Planning Program offers education, counseling, exams, lab testing, infertility services and contraceptives. Please refer to Section B., Agency Capacity.

### Pregnant Women and Infants

The Optimal Pregnancy Outcome Program (OPOP) provides multi-disciplinary teams committed to

enhance the prenatal care women receive from their primary health care provider. Please refer to Section B., Agency Capacity.

The ND Section of the American College of Obstetricians and Gynecologists, through its involvement in the Providers' Partnership Project, have developed a clinical model to assist primary care providers to screen for depression in the clients. The OPOP Director, Tobacco Prevention and Control Director, Mental Health Association and several practicing OB/GYN's make up the Providers' Partnership Committee on Women and Depression.

### Family Leadership and Support Programs

There are four family-led organizations in ND that provide leadership and support to families. They include Family Voices (health information for CSHCN), the Family-to-Family Network (parent-to-parent support), Pathfinder Family Center (education), and the Federation of Families (mental health). The state CSHCN program contracts with the first two organizations to provide emotional support, health information, and training for families in the state. CSHS staff also participate on their respective advisory boards.

Family support is also provided through various programs that serve CSHCN's and their families. For example, CSHS supports a nine member Family Advisory Council to assure family involvement in policy, program development, professional education, and delivery of care. Families participate on many other Title V led committees. Experienced parents have been hired as staff at many of the state's regional Human Service Centers to help families who have young children with disabilities. Lastly, the ND Center for Persons with Disabilities through Minot State University has received several grants to address a variety of family leadership and support issues.

## F. HEALTH SYSTEMS CAPACITY INDICATORS

### Form 17

01: The rate of children hospitalized for asthma (ICD-9 Codes: 493.0-493.9) per 10,000 children less than five years of age.

Due to the unavailability of hospital discharge claims data for individuals with private insurance, the most recent asthma hospitalization discharge rates are from 2000. That year the rate per 100,000 children under age four was 15.0.

02: The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

The percent of Medicaid enrollees under age one with an initial or periodic screen has increased steadily from 44.7 percent in 1995 to 78.1 percent in 2004.

03: The percent State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

The ND SCHIP plan was initiated in 1999. Since 2002, at least 80 percent of enrollees under age one have received a periodic screen.

04: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck index.

In 2004, 88.0 percent of ND women received adequate prenatal care as measured by the Kotelchuck index. This percent has changed little in the last five years.

07: The percent of EPSDT eligible children ages six through nine (6-9) years who have received any

dental services during the year.

Since 2002, less than half of all children ages six through nine (6-9) in the Medicaid EPSDT program have received dental services each year. For 2004, it is 34.7 percent.

08: The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.

The percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State Children with Special Health Care Needs (CSHCN) Program remained at about nine percent over the last five years.

#### Form 18

05: Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State.

- a) Percent of low birth weight (<2,500 grams)
- b) Infant deaths per 1,000 live births
- c) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester
- d) Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80 percent {Kotelchuck index})

The percent of low birth weight and infant deaths are higher for those women on Medicaid. The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester and the percent of pregnant women with adequate prenatal care is lower for those women on Medicaid.

06: The percent of poverty level for eligibility in the State's Medicaid programs for infants (0-1), children, Medicaid and pregnant women.

- a) Infants (0-1)
- b) Medicaid Children
- c) Pregnant Women

Eligibility levels have remained unchanged for all of the identified population groups over the last several years.

06: The percent of poverty level for eligibility in the State's SCHIP programs for infants (0-1), children, SCHIP and pregnant women.

- a) Infants (0-1)
- b) Medicaid Children
- c) Pregnant Women

Eligibility levels have remained unchanged for all of the identified population groups over the last several years.

#### Form 19

## 09A

### Annual Data Linkages

#### Annual linkages of infant birth and infant death certificates

Birth and infant death certificates have been linked and made available electronically to Title V staff since 1994. These linked files have been analyzed for program planning purposes.

#### Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files

Birth certificate files and Medicaid eligibility claims files have been linked on several occasions for specific analytic projects. Title V staff have direct access to the electronic Medicaid records.

#### Annual linkage of birth certificates and WIC eligibility files

To date, birth certificate and WIC files have not been linked. The ND WIC Program has recently developed a new client data system. It is anticipated that linkage of birth certificate and WIC files will occur during the upcoming year.

#### Annual linkage of birth certificates and newborn screening files

Birth certificate and newborn screening files have been linked since 1996. This linkage has helped identify the characteristics of infants not screened as well as assess the characteristics of women who breastfeed at hospital discharge.

### Registries and Surveys

#### Hospital discharge survey for at least 90 percent of the In-State discharges

Title V staff have electronic access to hospital discharge data. This data has been analyzed by program staff for a number of programmatic purposes.

#### Annual birth defects surveillance system

The state has developed a passive birth defects monitoring system. Title V staff manage the database and data is available electronically for program planning purposes.

#### Survey of recent mothers at least every two years (like PRAMS)

ND completed a Point-In-Time PRAMS Survey in 2002 and issued its ND PRAMS report in 2004.

## 09B

### Adolescent Tobacco Use

ND participates in the Youth Risk Behavior Survey (YRBS) and has access to the database for analysis. The percent of ND high school students considered current cigarette smokers has decreased from 40.6 percent in 1999 to 30 percent in 2003.

## 09C

### Overweight/Obesity

ND participates in the Youth Risk Behavior Survey (YRBS), the Pediatric Nutrition Surveillance System (PedNSS), and has WIC Program Data. There is direct access to the databases for analysis.



## **IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES**

### **A. BACKGROUND AND OVERVIEW**

Preparation for the five-year needs assessment began in early 2004. An initial workgroup comprised of representatives from the state Children with Special Health Care Needs Program in the ND Department of Human Services and five of the six divisions in the Department of Health Community Health Section (Family Health, Nutrition and Physical Activity, Injury Prevention, Tobacco Control, and Chronic Disease). Throughout the process, informal collaboration occurred with the Primary Care Association, the Primary Care Office and family organizations such as Family Voices and the CSHS Family Advisory Council.

The first task of the workgroup was to identify a list of data sources and indicators. The data sources were divided into two groups: primary sources and secondary sources. The indicators were categorized as 1) population and demographic, 2) pregnant women, mothers and infants, 3) children, 4) children with special healthcare needs, and 5) health system capacity indicators. The indicators for the three MCH population groups were further grouped as either health status, health care access or utilization, or health risk indicators.

Data collected were presented at a two-day planning retreat held in October 2004. The retreat was attended by more than forty Title V staff and state and community partners and stakeholders. The retreat facilitator led participants through a need prioritization process organized within three MCH Population groups: women, mothers and infants, children and adolescents, and children with special health care needs. Each group identified priority needs but were unable to rank them according to importance. The women, mothers and infants group identified 12 needs, the children and adolescents group 11 needs, and the children with special health care needs group 13 needs. Each group then wrote specific need statements for each of the priority needs. Following is a list of the priority needs.

#### Children and Adolescents

- \* To increase physical activity among pre-school and school age children.
- \* To reduce the rate of intentional and unintentional injury among children and adolescents.
- \* To improve early intervention for children with mental health and substance abuse disorders.
- \* For children with mental health and substance abuse disorders to receive appropriate treatment.
- \* To reduce marijuana use among children and adolescents.
- \* To reduce the rate of underage drinking.
- \* To reduce exposure to second hand smoke among children and adolescents.
- \* To reduce tobacco use among children and adolescents.
- \* To increase the percent of healthy weight among children and adolescents.
- \* To reduce the number of teens engaging in sexual activity.
- \* To improve access to health care (i.e. dental, mental health, school health).

#### Women, Mothers and Infants

- \* To increase access to dental services for low-income women.
- \* To improve early intervention of mental health and substance abuse disorders in women.
- \* To increase physical activity among women.
- \* To increase healthy weight among women.
- \* To improve early access to prenatal care among low-income populations.
- \* To increase the initiation and duration of breastfeeding.
- \* To decrease the rate of SIDS among American Indians.
- \* To increase the number of women consistently screened for domestic violence.
- \* To increase access to screening for mental health and wellness of infants.
- \* To increase access to preventive care.
- \* To reduce tobacco use among all women of child bearing age.
- \* To increase the rate of pregnancies that are intended.

## Children with Special Health Care Needs

- \* To reduce the incidence of diabetes among children.
- \* To reduce the percent of inpatient hospitalization due to mental health and behavioral disorders among children.
- \* To improve/increase geographic access to pediatric specialty care providers.
- \* To improve access to children's mental health services.
- \* To improve the capacity to monitor newborns diagnosed with hearing loss.
- \* To reduce the impact of chronic health conditions on children.
- \* To reduce the impact of chronic health conditions on families.
- \* To reduce family financial hardship due to child's health care expenses.
- \* To increase care coordination within medical homes.
- \* To increase transition services for youth with special health care needs.
- \* To increase the availability of family support services -- including quality respite and childcare.
- \* To improve cultural competence in the service delivery system.
- \* To increase information and awareness about available services.

## B. STATE PRIORITIES

After the retreat, three small workgroups were formed for each of the three population groups. Workgroups members consisted of Title V staff with programmatic expertise about specific needs as well as outside stakeholders. Workgroup members worked through a process designed to sort the priority needs for their population group into one of three lists based on the following criteria:

A List: This is a developmental need. It's a priority but we need to get more information or research intervention strategies.

B List: This priority need is already addressed through one of the 18 federal performance measures OR it is something we are already doing and will continue to do. (e.g. mandated programs/grants)

C List: All of the other priority needs not on the A or B List.

For those left on the C List we asked the following questions:

- \* Can we collaborate with someone else who has primary responsibility for the priority need (e.g. Healthy ND)?
- \* Do we have the resources needed to address the priority need?
- \* Do we know if there are effective interventions?
- \* Do we have baseline data and can we track improvement?

Based on the answers to these questions, we decided:  
Should this be one of the 7-10 state performance measures?

Based on this criteria, ten priority needs were selected which were chosen for the ten state "negotiated" performance measures for the next five-year grant cycle. Those ten priority needs and performance measures are:

### Priority Need Statement 1

To increase physical activity and healthy weight among women.

### State Performance Measure 1

The percent of healthy weight among women age 18-44.

### Priority Need Statement 2

To increase the initiation and duration of breastfeeding.

### State Performance Measure 2

The percent of women breastfeeding their infants at 6 months or longer.

Priority Need Statement 3

To increase access to dental services for low-income women.

State Performance Measure 3

The percent of women ages 18-44 enrolled in Medicaid who receive a preventive dental service.

Priority Need Statement 4

To increase access to preventive health services for women.

State Performance Measure 4

The degree to which women ages 18-44 have access to preventive health services as measured by five indicators of health care access.

Priority Need Statement 5

To reduce the rate of intentional and unintentional injuries among children and adolescents.

State Performance Measure 5

The rate of deaths to children age 1-19 caused by intentional and unintentional injuries per 100,000 children.

Priority Need Statement 6

To increase physical activity among pre-school and school-age children.

State Performance Measure 6

The percent of children age 6-17 who exercised or participated in a physical activity that made him/her sweat and breathe hard, such as basketball, soccer, running, or similar aerobic activities on five or more days during the past week.

Priority Need Statement 7

To increase the percent of healthy weight among children and adolescents.

State Performance Measure 7

The percent of ND children age 2-17 with a Body Mass Index (BMI) in the normal weight range.

Priority Need Statement 8

To reduce the impact of chronic health conditions on children.

State Performance Measure 8

The degree to which the state can assess and plan for the health and related service needs of children with extraordinary medical needs. NOTE: The complete ranking is included as an attachment to this section.

Priority Need Statement 9

To improve geographic access to pediatric specialty care providers.

State Performance Measure 9

The percent of families who reported they "had no problem at all" in getting care for their child from a specialist doctor.

Priority Need Statement 10

To increase information and awareness about available services.

State Performance Measure 10

The percent of activities completed in the CSHS Public Information Services plan.

After the selection of the state's 10 priority needs and development of state-negotiated performance measures, individual staff persons from the MCH program were assigned primary responsibility for each national and state performance measure that closely related to their programmatic area of expertise. CSHS program staff opted to work on CSHCN related performance measures as a group. The SSDI coordinator, who works with both Title V programs, was responsible for the collection and reporting of data for each measure and for monitoring the overall process.

For each assigned performance measure, staff were directed to write an annual plan and a process to monitor the successful completion of the activities, that was designed to impact the performance measure. Staff were also required to write an annual report for their assigned performance measure in which they commented on achievement of the objectives and summarized progress on the work plan activities. Staff were provided trend data for their measure(s) from which they provided five-year target projections.

Staff from both MCH and CSHS meet quarterly and discuss progress on their measures and discuss potential additional activities to be included in the next year's annual plan. In addition, CSHS staff review the plan related to CSHCN measures quarterly at staff meetings. For national performance measure #1 related to newborn screening, both programs have responsibility for the measure; MCH is responsible for the screening and CSHS for treatment services for affected individuals.

North Dakota has adequate capacity and resources to address most federal performance measures. MCH programs are spread primarily among three divisions within the Community Health Section in the DoH. Although the program has relatively small numbers of staff persons, MCH has experienced, qualified individuals administering injury prevention, oral health, nutrition, family planning, adolescent health and MCH nursing programs. The injury prevention program coordinates much of the programmatic activity for performance measures related to reduction of mortality and injury. The abstinence program grant manager has the responsibility for the measure related to teen birth rate. The newborn screening program director reports on the newborn screening measure. The MCH nutritionist has the responsibility for the breastfeeding measure. The maternal/infant nurse consultant has the responsibility for the measures related to low birth weight and prenatal care.

MCH program staff have little direct impact on the federal performance measures for childhood immunization, children without health insurance, children receiving a service paid by the Medicaid program, and VLBW infant born at facilities for high-risk deliveries. Most activities are collaboration efforts with other programs and agencies such as the Division of Disease Control and the state Medicaid Program.

CSHS program staff have responsibility for the six federal measures for CSHCN in addition to the measure for newborn hearing screening. For national performance measure #1, CSHS has programmatic responsibility for treatment of eligible individuals with metabolic diseases. CSHS provides metabolic food to eligible individuals with PKU and MSUD. CSHS also has direct responsibility for the newborn hearing screening performance measure.

CSHS has developed program plans to impact the five other new national performance measures for CSHCN (family partnership and satisfaction, medical home, insurance, community-based service system organization, and transition). However, the state CSHCN program directly serves only a fraction of all CSHCN in the state, therefore making direct impact on any of the measures difficult.

## State Performance Measures

Title V staff have the capacity and resources to carry out activities that are expected to impact each of the state selected performance measures. The Nutrition and Physical Activity Division in the Community Health Section has experienced public health nutritionists with expertise in designing interventions to address physical activity and healthy weight in children and women of child bearing age. The MCH nutritionist, along with local public health nutritionists, administer a number of

programs to encourage healthy diet and exercise practices which help to promote healthy weight in children and young adults. The MCH oral health director, in collaboration with local oral health professionals, help to increase access to dental care for low income populations in the state. Staff within the Injury Prevention Division in the Community Health Section work collaboratively with other stakeholders, including the Department of Transportation, to reduce unintentional injuries among children.

Pediatric nurses with the CSHS program work collaboratively with a number of entities to reduce the impact of chronic illness in children and to increase awareness of available programs and services for CSHCN and their families. CSHS staff also work to assist eligible children with special health care needs to access specialty care physicians as needed.

## C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				100	100
Annual Indicator			100.0	100.0	100.0
Numerator			6	6	8
Denominator			6	6	8
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	100	100	100	100	100

### a. Last Year's Accomplishments

CSHS provided financial support through a service contract for four multidisciplinary metabolic disorders clinics during the year. 14 individuals were served with a total of 19 visits.

CSHS provided metabolic food for 21 eligible individuals with PKU and MSUD.

CSHS provided state level care coordination services to eligible individuals with PKU and MSUD. Examples of care coordination services include assistance with insurance issues, coordination with providers, family support, links to local community resources, information on metabolic products, state metabolic team coordination, and communication between families, providers and state programs.

CSHS policy and procedures related to administration of the metabolic food program were reviewed monthly at metabolic meetings and updated as needed.

Newborn screening was expanded to include tandem mass spectrometry.

MCH website includes newborn screening content including updated parent brochure and listing of screened conditions/disorders.

Newborn screening files were linked with birth records.

The Newborn Screening Advisory Committee met four times during the fiscal year. Title V staff participate on the Genetics Advisory Committee.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHS will support multidisciplinary clinics for children and women of childbearing age with metabolic disorders.	X			
2. CSHS will provide metabolic food to eligible individuals with PKU and MSUD.	X			
3. CSHS will provide long term follow-up services through state level care coordination to eligible individuals with PKU and MSUD.		X		
4. The Metabolic Program Procedure Guide used in CSHS will be updated as needed.				X
5. The Newborn Screening Advisory Committee will meet by conference call at least four times during 2006				X
6. Start screening for Cystic Fibrosis as a pilot project.			X	
7. Distribution and education of the NBS Guidelines to healthcare agencies.				X
8. Distribution of Parent Fact Sheets to healthcare agencies.			X	
9. Title V staff will participate in the Heartland Genetics and Newborn Screening Collaborative.				X
10.				

#### b. Current Activities

The MCH Newborn Screening Program follow-up policies and procedures will be revised and updated, including the expanded MS/MS screening follow-up.

The Newborn Screening Program Advisory Group will meet by conference call at least four times during 05.

Transitioning the Newborn Screening Program from the Division of Nutrition & Physical Activity to the Division of Family Health will be investigated.

Bring the new Iowa Biochemical Geneticist, Dr. Sara Copeland, to North Dakota to meet with Newborn Screening Program, CSHS Staff and Advisory Committee members and if possible to speak at the 2005 meeting of the North Dakota Academy of Pediatrics.

CSHS will support multidisciplinary clinics for children and women of childbearing age with metabolic disorders.

CSHS will provide metabolic food to eligible individuals with PKU and MSUD.

CSHS will provide state level care coordination to eligible individuals with PKU and MSUD.

CSHS staff will participate on the newborn screening advisory committee.

**c. Plan for the Coming Year**

CSHS will support multidisciplinary clinics for children and women of childbearing age with metabolic disorders.

CSHS will provide metabolic food to eligible individuals with PKU and MSUD.

CSHS will provide long term follow-up services through state level care coordination to eligible individuals with PKU and MSUD.

The Metabolic Program Procedure Guide used in CSHS will be updated as needed.

The Newborn Screening Advisory Committee will meet by conference call at least four times during 2006.

Start screening for Cystic Fibrosis as a pilot project.

Distribution and education of the NBS Guidelines to healthcare agencies.

Distribution of Parent Fact Sheets to healthcare agencies.

Title V staff will participate in the Heartland Genetics and Newborn Screening Collaborative.

**Performance Measure 02:** *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective				61.5	61.5
Annual Indicator			61.5	61.5	61.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual					

Performance Objective	61.5	65	65	65	65
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### Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

### Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

### Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

#### a. Last Year's Accomplishments

Family satisfaction with CSHS clinics was assessed through a family Needs Assessment Survey and a phone survey of families. 96.5 percent of respondents were satisfied with services their child received at clinics. 98 percent of families attending reported that evaluations and plans of care helped them manage their child's condition. Family satisfaction with services for CSHCN was also measured through a series of six focus groups held throughout the state.

CSHS offered financial support and reimbursement to Family Advisory Council members to support participation in quarterly meetings of the council as well as topical meetings of interest and CSHS training related events. CSHS utilized a process to record advice and recommendations from Advisory Council members for consideration in program and policy decisions.

CSHS provided financial support through contracts to two family organizations in the state: Family Voices of ND and the Family-to-Family Support Network. CSHS staff members serve on the board of these two organizations. CSHS staff also served on the advisory committee to the state family support project. Staff attended and made a presentation at a statewide family support conference.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHS will continue to assess client satisfaction as one of the measures of quality assurance in service contracts administered by the State CSHCN program.				X
2. CSHS will continue to include family advice and recommendations from a Family Advisory Council when making program and policy decisions.				X
3. CSHS will support the activities of family organizations in the state by providing financial assistance through contracts and serving on advisory boards as requested.		X		
4. CSHS will conduct a telephone survey to determine the percent of individuals/families served by CSHS reporting services received met their needs.				X
5.				
6.				
7.				
8.				

9.				
10.				

#### b. Current Activities

CSHS will continue to include family advice and recommendations from a Family Advisory Council when making program and policy decisions.

CSHS will support the activities of family organizations in the state by providing financial assistance through contracts and serving on advisory boards as requested.

CSHS will continue to include client satisfaction assessments as part of overall quality assurance efforts in CSHS service contracts.

#### c. Plan for the Coming Year

CSHS will continue to assess client satisfaction as one of the measures of quality assurance in service contracts administered by the State CSHCN program.

CSHS will continue to include family advice and recommendations from a Family Advisory Council when making program and policy decisions.

CSHS will support the activities of family organizations in the state by providing financial assistance through contracts and serving on advisory boards as requested.

CSHS will conduct a telephone survey to determine the percent of individuals/families served by CSHS reporting services received met their needs.

**Performance Measure 03:** *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				54.7	54.7
Annual Indicator			54.7	54.7	54.7
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	54.7	60	60	60	60

**Notes - 2002**

The 2002 indicator is based on the State estimates from SLAITS.

### Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

### Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

#### a. Last Year's Accomplishments

CSHS provided information on medical homes for CSHCNs to providers and families. The state office sent information to 30 individuals via well child/immunization information packets. Family Voices, an organization that CSHS contracts with to provide family health information services, provided information to an additional 84.

The state received a CATCH grant, which focused on medical homes for CSHCN. The ND CATCH team held three planning meetings during the year. Initial activities included an assessment of knowledge, interest, and gaps in medical homes for CSHCN.

CSHS monitored the medical home status of children served through CSHS and receiving Medicaid. 78 percent of children served through the CSHS Care Coordination Program were determined to have a medical home. In Medicaid's 2004 customer survey, 82.4 percent of respondents in the Women, Families and Children aid category indicated they had one person they thought of as their personal doctor, who they saw most of the time.

CSHS provided care coordination through county social services and public health nursing staff. 97 percent of children receiving care coordination services had a written, comprehensive service plan, 93 percent of which were current.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHS will provide information on medical homes for CSHCNs to providers and families.			X	
2. CSHS will collaborate with partners who are interested in exploring next steps toward furthering the medical home concept and practice in North Dakota. Partners could include IHS, AAP, family organizations, providers, ECCS, MA, EHDI, etc.				X
3. CSHS will monitor the medical home status of children receiving care coordination services through CSHS.				X
4. CSHS will monitor the percentage of children receiving CSHS care coordination services with a comprehensive, written service plan.				X
5. CSHS will work through the Champions for Progress Team to further the Medical Home concept in ND.				X
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

CSHS will provide information on medical homes for CSHCNs to providers and families.

CSHS will collaborate with partners to further the medical home concept and practice in North Dakota. Partners could include Indian Health Service, ND Chapter of the American Academy of Pediatrics, family organizations, providers, Early Childhood Comprehensive Systems, Medicaid PCP Program, Early Hearing Detection and Intervention, etc.

CSHS will monitor the medical home status of children receiving care coordination services through CSHS and Medicaid-eligible children.

Increase the percentage of children receiving CSHS care coordination services with a comprehensive, written service plan.

### c. Plan for the Coming Year

CSHS will provide information on medical homes for CSHCNs to providers and families.

CSHS will collaborate with partners who are interested in exploring next steps toward furthering the medical home concept and practice in North Dakota. Partners could include Indian Health Service, ND Chapter of the American Academy of Pediatrics, family organizations, providers, Early Childhood Comprehensive Systems, Medicaid PCP Program, Early Hearing Detection and Intervention, etc.

CSHS will monitor the medical home status of children receiving care coordination services through CSHS.

CSHS will monitor the percentage of children receiving CSHS care coordination services with a comprehensive, written service plan.

CSHS will work through the Champions for Progress Team to further the Medical Home concept in ND.

**Performance Measure 04:** *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				62	62
Annual Indicator			62	62	62
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final

	2005	2006	2007	2008	2009
Annual Performance Objective	62	65	65	65	65

#### Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

#### Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

#### Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

#### a. Last Year's Accomplishments

94 percent of CSHCN's served by CSHS had a source of health care coverage during the year. Underinsurance was assessed through the National Survey of CSHCN and a CSHS Family Needs Assessment Survey.

CSHS has policies in place regarding coordination of payment between all available sources of health care coverage. Families applying for treatment services through CSHS are required to verify Medicaid and CHIP eligibility as part of the application process. If ineligible, families are linked to other available resources. Annually, state CSHCN staff target outreach mailings to families with uninsured children served through CSHS clinics to link them to available sources of health care coverage such as Medicaid, CHIP and Caring programs.

CSHS provided diagnostic services to 107 children and treatment services to 210 children during the year.

CSHS staff attended Medicaid claims meetings in order to keep abreast of claims payment issues with potential impact on CSHS. State CSHCN staff also routinely attended policy meetings with administrative staff in the Medical Services Division to keep informed about Medicaid coverage decisions and to influence policies developed for CSHCN's and their families.

Covering Kids meeting minutes were reviewed to monitor activities. Staff within the DoH and the Medical Services Division of the DHS attended meetings.

#### Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHS will monitor the number of CSHCNs served by CSHS with a source of health care coverage and assess underinsurance issues for special demographic characteristics of CSHCN.				X
2. CSHS will conduct activities to refer and link families that have CSHCN to available sources of health care coverage such as Medicaid, CHIP and Caring programs.		X		
3. CSHS will provide diagnostic and treatment services to eligible uninsured and underinsured CSHCN.	X			
4. CSHS staff will participate in meetings within Medical Services related to claims payment, Medicaid policy, or services to CSHCN and their				X

families.				
5. CSHS staff will monitor the developments of state Covering Kids and Families grant.				X
6. CSHS will participate in work activities to support the rewrite of the Medicaid Management Information System (MMIS).				X
7.				
8.				
9.				
10.				

#### b. Current Activities

CSHS will monitor the number of CSHCN's served by CSHS with a source of health care coverage and assess underinsurance issues for special demographic characteristics of CSHCN.

CSHS will conduct activities to refer and link families that have CSHCN to available sources of health care coverage such as Medicaid, CHIP and Caring programs.

CSHS will provide diagnostic and treatment services to eligible uninsured and underinsured CSHCN.

CSHS staff will participate in meetings within Medical Services related to claims payment, Medicaid policy, or services to CSHCN and their families.

CSHS staff will monitor the developments of the state Covering Kids grant.

CSHS will disseminate results from the CSHCN SLAITS and CSHS Family Surveys that pertain to health insurance coverage.

CSHS staff will monitor any health care legislation that impacts children as well as policy changes that affect Medicaid eligibility or covered services.

CSHS will explore collaboration with Medicaid to explore models of chronic disease management.

#### c. Plan for the Coming Year

CSHS will monitor the number of CSHCNs served by CSHS with a source of health care coverage and assess underinsurance issues for special demographic characteristics of CSHCN.

CSHS will conduct activities to refer and link families that have CSHCN to available sources of health care coverage such as Medicaid, CHIP and Caring programs.

CSHS will provide diagnostic and treatment services to eligible uninsured and underinsured CSHCN.

CSHS staff will participate in meetings within Medical Services related to claims payment, Medicaid policy, or services to CSHCN and their families.

CSHS staff will monitor the developments of state Covering Kids and Families grant.

CSHS will participate in work activities to support the rewrite of the Medicaid Management

**Performance Measure 05:** *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective				83.4	83.4
Annual Indicator			83.4	83.4	83.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	83.4	85	85	85	85

#### Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

#### Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

#### Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

#### a. Last Year's Accomplishments

CSHS conducted an annual training for county social service workers and public health care coordinators in October 2003. 47 people attended and evaluations were positive. Topics covered included cultural competency, CSHS policies/procedures, transition service planning, metabolic disorders, and a family presentation. State CSHCN staff provided technical assistance to county social service workers, public health care coordinators, and contracted service providers via phone, e-mail, and periodic site visits.

Annually, CSHS develops a Public Information Plan. For FY 2004, 26 out of 29 plan activities were completed (90 percent). A Public Information report is available.

CSHS staff participated on 33 interagency workgroups and committees during FFY 2004.

The CSHS program supported ten different types of clinics during FFY 2004, seven of which were funded through service contracts, and three of which were directly managed by state CSHCN staff.

CSHS staff facilitated a statewide clinic coordinators meeting in August of 2004. New members participated in the clinic coordinators meeting.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHS will enhance capacity of local staff to implement CSHS programs by providing technical assistance and an annual training opportunity for county social service staff and public health nurses.				X
2. CSHS staff will participate in interagency workgroups and committees whose focus is improved access to services for CSHCN.				X
3. CSHS will directly manage and fund a variety of multidisciplinary clinic services for CSHCNs and their families.	X			
4. CSHS will collaborate with other stakeholders to enhance the multidisciplinary clinic infrastructure in the state by conducting a clinic coordinator meeting.				X
5. CSHS will work through the Champions for Progress Team to implement community-based systems of care for children and youth with special health needs and their families.				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

CSHS will enhance capacity of local staff to implement CSHS programs by providing technical assistance and an annual training opportunity for county social service staff and public health nurses.

CSHS will provide public information services to improve access to care including operation of a family resource center.

CSHS staff will participate in interagency workgroups and committees whose focus is improved access to services for CSHCN.

CSHS will directly manage and fund a variety of multidisciplinary clinic services for CSHCNs and their families.

CSHS will collaborate with other stakeholders to enhance the multidisciplinary clinic infrastructure in the state by conducting a clinic coordinator meeting.

**c. Plan for the Coming Year**

CSHS will enhance capacity of local staff to implement CSHS programs by providing technical assistance and an annual training opportunity for county social service staff and public health nurses.

CSHS staff will participate in interagency workgroups and committees whose focus is improved access to services for CSHCN.

CSHS will directly manage and fund a variety of multidisciplinary clinic services for CSHCNs and their families.

CSHS will collaborate with other stakeholders to enhance the multidisciplinary clinic infrastructure in the state by conducting a clinic coordinator meeting.

CSHS will work through the Champions for Progress Team to implement community-based systems of care for children and youth with special health needs and their families.

**Performance Measure 06:** *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective				5.8	5.8
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	5.8	10	10	10	10

#### Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

#### Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

#### Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure.

#### a. Last Year's Accomplishments

CSHS has begun to collaborate with others regarding transition. Staff from the Department of Public Instruction provided a presentation on transition at a CSHS Family Advisory Council meeting. A CSHS staff member was invited to participate on the State Transition Steering Council led by the Department of Public Instruction. CSHS conducted a health transition outreach mailing targeting 469 families served by CSHS with youth ages 14-21.

CSHS continues to monitor the level of transition service planning for children ages 14-21 for CSHCNs served by CSHS with written service plans. During FY 2004, 43 percent of children age 14-21 had an assessment or service plan that addressed transition issues.

CSHS implemented bylaw changes, which allows youth or young adults with special health care needs to serve on the CSHS Family Advisory Council. An adolescent attended the CSHS annual county training event and a Family Advisory Council meeting.

CSHS completed an annual SSI report in order to monitor the status of the SSI population. CSHS staff also conducted information and referral mailings to 80 children receiving SSI and their families. An annual meeting was held in August 2004 with Medicaid, the Social Security Administration, Disability Determination Services, and state CSHCN program staff.

Transition was promoted at the annual clinic coordinator meeting. Discussions focused on transition at various developmental stages and Kids As Self Advocates (KASA).

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHS will collaborate with state agencies and family organizations to promote health care transitions for CSHCN (e.g.) Champions for Progress, Transition Steering Council, etc.				X
2. CSHS will monitor the level of transition service planning for children ages 14-21 for CSHCNs served by CSHS with written service plans.				X
3. CSHS will monitor the status and provide information and referral services to the SSI population and collaborate with other stakeholders involved with children's SSI.				X
4. CSHS will promote transition through multidisciplinary clinics.	X			
5. CSHS will disseminate health care transition resources.			X	
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

CSHS will collaborate with state and local entities and family organizations to promote health care transitions for CSHCN.

CSHS will monitor the level of transition service planning for children ages 14-21 for CSHCN's served by CSHS with written service plans.

CSHS will explore the inclusion of youth or young adults with special health care needs on the Family Advisory Council when recruiting members.

CSHS will monitor the status and provide information and referral services to the SSI population and collaborate with other stakeholders involved with children's SSI.

CSHS will explore development and dissemination of "health" transition resources.

### c. Plan for the Coming Year

CSHS will collaborate with state agencies and family organizations to promote health care transitions for CSHCN (e.g.) Champions for Progress, Transition Steering Council, etc.

CSHS will monitor the level of transition service planning for children ages 14-21 for CSHCNs served by CSHS with written service plans.

CSHS will monitor the status and provide information and referral services to the SSI population and collaborate with other stakeholders involved with children's SSI.

CSHS will promote transition through multidisciplinary clinics.

CSHS will disseminate health care transition resources.

**Performance Measure 07: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.**

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	83.5	84	82	79	79.5
Annual Indicator	80.3	78.7	77.7	80.4	78.4
Numerator	18956	18578	18342	18979	18507
Denominator	23606	23606	23606	23606	23606
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	80	80.5	81	81.5	81.5

### a. Last Year's Accomplishments

Local Public Health Units received funding to provide immunizations to the children in their communities.

Ongoing, collaboration with the Immunization Program.

Provided training/updates to public health, school nurses, childcare and head start on varicella vaccine recommendations and other immunization updates in collaboration with the Immunization Program.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to collaborate with the Immunization Program through the Memorandum of Agreement.				X
2. Collaborate with the Immunization Program to provide trainings/updates to public health, school nurses, childcare and head start on immunization recommendations.				X
3. Provide funding to local public health units to fund immunization administration.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Continued to collaborate with the Immunization Program through the Memorandum of Agreement.

Collaborate with the Immunization Program to provide trainings/updates to public health, school nurses, childcare and head start on immunization recommendations.

Provide funding to local public health units to fund immunization administration.

**c. Plan for the Coming Year**

Continue to collaborate with the Immunization Program through the Memorandum of Agreement.

Collaborate with the Immunization Program to provide trainings/updates to public health, school nurses, childcare and head start on immunization recommendations.

Provide funding to local public health units to fund immunization administration.

**Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.***

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance	16.8	16.1	16.1	12	11.5

Objective					
Annual Indicator	14.7	12.3	11.5	10.9	10.2
Numerator	639	562	523	492	462
Denominator	43341	45512	45512	45339	45339
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	10	10	9.5	9.5	9

#### a. Last Year's Accomplishments

Abstinence funding was granted to the eight regions of the state.

Each region planned abstinence activities in their schools and communities.

Regional activities included producing a DVD to be used in the schools and communities, using the program "Postponing Sexual Involvement", multimedia campaign, providing abstinence resources to communities, as well utilizing abstinence speakers throughout their communities.

The Abstinence Education coordinator and family planning nurse consultant are combined into one position has led to increase collaboration efforts to decrease the number of teen births.

#### Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with Family Planning, Adolescent Health, STD and HIV programs and the Department of Public Instruction as part of regional stakeholders group.				X
2. Seven regions throughout the state have been granted funding to provide and plan Abstinence programming in their local communities.				X
3. Regions 3,4 and 6 will develop a media campaign on the Abstinence-only message targeting the teen population.			X	
4. Provide technical assistance to the local grantees to provide quality Abstinence Education with their present and future programming.				X
5. Family Planning services will continue to be available through nine delegate agencies and 11 satellite clinics.				
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

There are 2 CSCC'S, 4 Regional Tribes, 1 Community Action Program, and 5 Public Health Units that have applied for the Abstinence Education Only Grant.

Regions 3, 4 and 6 continue to collaborate to provide an Abstinence Education Only Media Campaign targeting the teen population.

Communicate and collaborate with the local grantees to assist them in utilizing quality speakers and appropriate Abstinence Education Only educational materials.

Continue to collaborate with appropriate partners such as Family Planning and Adolescent Health to support the efforts in reducing teen births.

#### c. Plan for the Coming Year

Collaborate with Family Planning, Adolescent Health, STD and HIV programs, as well as the Department of Public Instruction as part of a regional stakeholders group.

Seven regions throughout the state have been granted funding to provide and plan Abstinence programming in their local communities.

Regions 3,4 and 6 will develop a media campaign on the Abstinence-only message targeting the teen population.

Provide technical assistance to the local grantees to provide quality Abstinence Education with their present and future programming.

**Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.***

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	53.5	54	54	54	55
Annual Indicator	53.6	53.6	53.6	53.6	53.6
Numerator	178	178	178	178	178
Denominator	332	332	332	332	332
Is the Data Provisional or Final?				Final	Provisional
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	56	57	58	59	60

#### a. Last Year's Accomplishments

The North Dakota Survey of Third Graders will start in January. The oral health consultants will work with a nutritionist to gather some height and weight data as well. 51 schools have been selected for the survey.

The research analyst for the oral health program is working on identifying any gaps in surveillance data.

Educational materials will be purchased.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The ND survey of third graders will start in January. The oral health consultants will work with a nutritionist to gather some height and weight data as well. 51 schools have been selected for the survey.				X
2. The research analyst for the oral health program is working on identifying any gaps in surveillance data.				X
3. Educational materials will be purchased.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Third grade survey to be conducted in August 2004, with analysis completed by 12/04

Continue coalition building and meeting of the Oral Health Coalition to identify strategies to work towards school based sealant programs.

Form and convene workgroups from the oral health coalition

**c. Plan for the Coming Year**

Provide a report to schools, nutritionists, and the dental community that participated in the 3rd grade oral health and height and weight survey.

The Oral Health Coalition and its partners will produce a state oral health plan. This plan will be frequently updated as new data is acquired.

Oral health work groups will be convening in August after completion of the state oral health plan.

**Performance Measure 10:** *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]				

<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	4.1	4.3	3.9	2.9	2.8
Annual Indicator	4.7	3.0	3.6	3.8	5.6
Numerator	5.7	11	13	14	21
Denominator	122109	366056	366056	366558	374218
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	4.7	4.5	4.3	4.1	3.9

#### **Notes - 2004**

Three-year averages are used to calculate rate to avoid fluctuations. Will monitor and continue with future year's objectives.

#### **a. Last Year's Accomplishments**

The car seat distribution project continued with approximately 50 local agencies distributing 2,288 car seats to families. 230 seats were provided to the five Indian reservations in the state.

The Injury Prevention Program assisted with 59 car seat checkup events, inspecting 1016 car seats. The program provided lead checkers, technicians, car seats and supplies for the events.

Child Passenger Safety Month was celebrated in February 2005 with the development of a new videotape, classroom presentation and educational materials for K-2. During the month, local agencies provided a buckle up message and supporting materials to 33,976 children, preschool through 6th grade.

Educational materials were distributed on an ongoing basis throughout the year to law enforcement, public health, hospitals, car seat distribution programs, Safe Communities programs, Safe Kids Coalitions, etc.

As part of its distribution project, the program provided 438 low-back boosters and 742 high-back boosters with harnesses.

The Boost, Then Buckle Program continued to encourage the use of booster seats by children 40 to 80 pounds. The program evaluated the effectiveness of its public awareness campaign through a survey of parents of kindergarten children. The survey found that 55 percent of respondents reported they had heard the Boost, Then Buckle message. Parents who seldom or never used a booster seat for their child were asked why. The most common reasons given were "my child is too big," "by law, it's not required," and "my child refuses to ride in a booster."

Planning began during this fiscal year to develop a child passenger safety kit (videotape, classroom presentation, and educational materials) for children in grades 3-6. The project will be implemented in February 2005 during Child Passenger Safety Month.

Conducted four 32-hour child passenger safety certification courses with 60 participants;

conducted two refresher courses for current technicians with 45 participants; Conducted six child passenger safety workshops ranging from 4 hours to 2 days with 94 participants.

Provided routine technical updates to technicians and assisted them in maintaining certification status.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Re-apply for ND Department of Transportation funds to administer the state's child passenger safety program; monitor expenditures, complete reports as required.				X
2. Continue educational efforts to increase the proper use of car seats through use of pamphlets, posters, displays, etc. Sponsor Child Passenger Safety Week in February 2006			X	
3. Develop an educational campaign to inform North Dakota parents and caregivers about changes in the state's child passenger safety law. Provide information on the appropriate restraint for their child's age, weight, height, and developmental level.			X	
4. Continue car seat distribution program throughout the state by providing car seats, policies/procedures, and training/technical assistance to local agencies. Provide car seats and training to five Indian reservations.				X
5. Assist local agencies in conducting car seat check-ups by providing certified instructors, technicians, car seats, and checkup supplies.				X
6. Continue educational efforts to encourage the use of recently-developed curriculums and videos for children grades K-2 and grades 3-6.			X	
7. Conduct 2-3 four-day NHTSA Standardized Child Passenger Safety Courses to certify new child passenger safety technicians. Conduct 2-3 refresher courses for current technicians and assist current technicians in meeting requirements for re-certificati				X
8. On an ongoing basis, provide technical assistance and updated information to technicians to maintain technical knowledge on child passenger safety issues. Write the "Buckle Update" section of the "Building Blocks to Safety" quarterly newsletter to p			X	
9.				
10.				

#### b. Current Activities

Re-apply for ND Department of Transportation funds to administer the state's child passenger safety program; monitor expenditures, complete reports as required.

Continue educational efforts to increase the proper use of car seats through use of pamphlets, posters, displays, etc. Sponsor Child Passenger Safety Week in February 2005.

Continue car seat distribution program throughout the state by providing car seats, policies/procedures, and training/technical assistance to local agencies. Provide car seats and training to five Indian reservations.

Assist local agencies in conducting car seat check-ups by providing certified instructors, technicians, car seats, and checkup supplies.

Continue coordinating the "Boost, Then Buckle" Campaign to encourage the use of booster seats by children from 40 to 80 pounds. Provide booster seats to local agencies to enhance the campaign.

Promote use of "Buckle Up With Bucky" videotape, curriculum and other materials for grades K-2.

Continue educational efforts to encourage the use of seat belt by children 3-6 through development of videotape, curriculum and other educational materials.

Conduct 2-3 four-day NHTSA Standardized Child Passenger Safety Courses to certify new child passenger safety technicians. Conduct 2-3 refresher courses for current technicians and assist current technicians in meeting requirements for re-certification.

On an ongoing basis, provide technical assistance and updated information to technicians to maintain technical knowledge on child passenger safety issues. Write the "Buckle Update" section of the "Building Blocks to Safety" quarterly newsletter to provide current information on child passenger safety.

Coordinate a bike safety project by providing technical assistance, training, educational materials, and bike helmets to local agencies. Continue to expand public information and education activities relating to bike helmet use.

Monitor child safety legislation during the 2005 Legislative session. Provide information as requested/appropriate.

### c. Plan for the Coming Year

Re-apply for ND Department of Transportation funds to administer the state's child passenger safety program; monitor expenditures, complete reports as required.

Continue educational efforts to increase the proper use of car seats through use of pamphlets, posters, displays, etc. Sponsor Child Passenger Safety Week in February 2006.

Develop an educational campaign to inform North Dakota parents and caregivers about changes in the state's child passenger safety law. Provide information on the appropriate restraint for their child's age, weight, height, and developmental level.

Continue car seat distribution program throughout the state by providing car seats, policies/procedures, and training/technical assistance to local agencies. Provide car seats and training to five Indian reservations.

Assist local agencies in conducting car seat check-ups by providing certified instructors, technicians, car seats, and checkup supplies.

Continue educational efforts to encourage the use of recently-developed curriculums and videos for children grades K-2 and grades 3-6.

Conduct 2-3 four-day NHTSA Standardized Child Passenger Safety Courses to certify new child passenger safety technicians. Conduct 2-3 refresher courses for current technicians and assist current technicians in meeting requirements for re-certification.

On an ongoing basis, provide technical assistance and updated information to technicians to maintain technical knowledge on child passenger safety issues. Write the "Buckle Update" section of the "Building Blocks to Safety" quarterly newsletter to provide current information on child passenger safety.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	59	62	59	62	63
Annual Indicator	58.4	61.7	61.2	60.9	61.3
Numerator	4944	4398	5285	5265	5528
Denominator	8465	7128	8636	8652	9018
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	64	65	66	67	68

**a. Last Year's Accomplishments**

The Healthy North Dakota Breastfeeding Work Group's strategic plan was finalized and activities began.

The findings of the Baby Friendly Hospital survey were reviewed and disseminated to at meetings and through e-mail lists, etc.

The media pieces (fact sheets, PowerPoint) on breastfeeding, for policy and environmental change in hospitals and worksites was not developed.

The State WIC Program provided local agencies with resources for promotion of World Breastfeeding Week in August 2004.

Funding did not permit so WIC did not purchase additional electric breast pumps for use by mothers who are returning to work or school. However pumps continue to be available.

Due to some organizational changes the web site development was delayed so the breastfeeding data was not placed on the site.

WIC/MCH staff helped plan the 6th Biennial ND Breastfeeding Conference, held in Bismarck in 2004 and 135 attended.

The Breastfeeding Lactation Counselor training is planned for November 2004.

Jill provided training to 2 Head Start, 2 Child care providers and 4 Child and Adult Care Food Program Sponsors on how to accommodate mothers that breastfeed and how to support infants and children who are breastfed.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH Nutritionist will continue as the Department's liaison to the Healthy North Dakota Breastfeeding Committee (HNDBC).				X
2. MCH nutritionist and other members of the HNDBC will work to assure that breastfeeding support is a component of worksite wellness initiatives of the Healthy North Dakota Worksite Wellness Committee.				X
3. MCH Nutritionist or other members of the HNDBC will work with the HND Third Party Payer Committee to promote reimbursement for lactation consultant services and electric breast pumps.				X
4. MCH Nutritionist or other members of the HNDBC will promote the implementation of Breastfeeding Friendly Hospital procedure in North Dakota hospitals.			X	
5. The state WIC Program will provide local agencies with resources for promotion of World Breastfeeding Week.			X	
6. If funding permits, WIC will purchase additional electric breast pumps for use by mothers who are returning to work or school.		X		
7. Work with Department's CDC epidemiologist and other data programs to get breastfeeding data on the Department's website.				X
8. WIC staff will continue implementing a WIC Peer Counseling Program in North Dakota (second year of a three-year project).		X		
9. Evaluate WIC site the WIC Motivational Interviewing Research Project, which includes increased breastfeeding duration as one of the evaluation components (final year of USDA Grant).				X
10.				

**b. Current Activities**

MCH Nutritionist will continue as the Department's liaison to the Healthy North Dakota Breastfeeding Committee (HNDBC).

MCH nutritionist and other members of the HNDBC will work to assure that breastfeeding support is a component of worksite wellness initiatives of the Healthy North Dakota Worksite Wellness Committee.

MCH Nutritionist or other members of the HNDBC will work with the North Dakota Workforce Safety and Insurance Program to include a breastfeeding component into a Worksite Wellness Incentive Program, which is under development.

MCH Nutritionist or other members of the HNDBC will work with the HND Third Party Payer Committee to promote reimbursement for lactation consultant services and electric breast pumps.

MCH Nutritionist or other members of the HNDBC explore the possibility of "Right to Breastfeed" legislation for the 2005 legislative session.

MCH Nutritionist or other members of the HNDBC will promote the implementation of Breastfeeding Friendly Hospital procedure in North Dakota hospitals.

The state WIC Program will provide local agencies with resources for promotion of World Breastfeeding Week.

Promote the Breastfeeding Lactation Counselor training which will be held November 8-12, 2004 in Grand Forks. WIC will financially support the attendance of about six WIC and Public Health Nursing personnel at the course.

Provide a breakout session on breastfeeding support in a child care setting at the Region VIII Head Start Early Childhood Professional Institute October 13th - 16th, 2004.

Provide training on breastfeeding support in a childcare setting to the Child and Adult Care Food Program (CACFP) Sponsors.

If funding permits, WIC will purchase additional electric breast pumps for use by mothers who are returning to work or school.

Work with Department's CDC epidemiologist and other data programs to get breastfeeding data on the Department's website.

WIC staff will investigate the appropriate ways to implement a WIC Peer Counseling Program in North Dakota (beginning of a three-year project).

Implement in two WIC site the WIC Motivational Interviewing Research Project, which includes increased breastfeeding duration as one of the evaluation components (USDA Grant).

### c. Plan for the Coming Year

MCH Nutritionist will continue as the Department's liaison to the Healthy North Dakota Breastfeeding Committee (HNDBC).

MCH nutritionist and other members of the HNDBC will work to assure that breastfeeding support is a component of worksite wellness initiatives of the Healthy North Dakota Worksite Wellness Committee.

MCH Nutritionist or other members of the HNDBC will work with the HND Third Party Payer Committee to promote reimbursement for lactation consultant services and electric breast pumps.

MCH Nutritionist or other members of the HNDBC will promote the implementation of Breastfeeding Friendly Hospital procedure in North Dakota hospitals.

The state WIC Program will provide local agencies with resources for promotion of World Breastfeeding Week.

If funding permits, WIC will purchase additional electric breast pumps for use by mothers who are returning to work or school.

Work with Department's CDC epidemiologist and other data programs to get breastfeeding data on the Department's website.

WIC staff will continue implementing a WIC Peer Counseling Program in North Dakota (second year of a three-year project).

Evaluate WIC site the WIC Motivational Interviewing Research Project, which includes increased breastfeeding duration as one of the evaluation components (final year of USDA Grant).

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	41	45	75	95	95
Annual Indicator	38.3	41.7	54.1	91.3	95.1
Numerator	3397	3693	4779	8104	8743
Denominator	8879	8847	8839	8877	9191
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	95.2	96	97	98	98

**a. Last Year's Accomplishments**

A state CSHCN staff member continues to serve on the grant management team of the state's EHDI program administered through the Center for Persons with Disabilities at Minot State University. The CSHS staff member functions as the state implementation coordinator. Work efforts during the year focused primarily on training and information dissemination through a variety of mediums.

CSHS conducted a mail survey of all birth hospitals in the state to assess newborn hearing screening. Of births that occurred in CY 2003, 95% were screened for hearing loss.

A CSHS staff member serves as the Title V state EHDI contact.

August 2003, national technical assistance was received that focused on improving follow up efforts. A follow-up plan was developed but implementation efforts were unsuccessful.

CSHS staff members continue dialogue with the Health Tracks Program Administrator. The screening ratio for EPSDT increased from 50 percent in 2003 to 60 percent in 2004. Home-based developmental screenings provided through the Right Track program have also been monitored.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. A CSHS staff member will serve on the grant management team and function as the state implementation coordinator for the EHDI Program.				X
2. CSHS will administer an annual newborn hearing screening survey to all birthing hospitals in the state.				X
3. A CSHS staff member will serve as the Title V state EHDI contact.				X
4. A CSHS staff will participate in stakeholders meetings regarding the tracking of infants through the hearing screening, referral, and the diagnostic process.				X
5. CSHS will monitor other early screening and detection systems for young children (e.g.) Health Tracks, Right Track, etc.				X
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

A CSHS staff member will serve on the grant management team and function as the state implementation coordinator for the EHDI Program.

If needed for monitoring purposes, CSHS will administer an annual newborn hearing screening survey to all birthing hospitals in the state.

A CSHS staff member will serve as the Title V state EHDI contact.

CSHS will analyze newborn hearing screening data and conduct short-term follow-up when EHDI grant activities are completed.

CSHS will monitor other early screening and detection systems for young children (e.g.) Health Tracks.

**c. Plan for the Coming Year**

A CSHS staff member will serve on the grant management team and function as the state implementation coordinator for the EHDI Program.

CSHS will administer an annual newborn hearing screening survey to all birthing hospitals in the state.

A CSHS staff member will serve as the Title V state EHDI contact.

A CSHS staff will participate in stakeholders meetings regarding the tracking of infants through the hearing screening, referral, and the diagnostic process.

CSHS will monitor other early screening and detection systems for young children (e.g.) Health Tracks, Right Track, etc.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	8.7	16.3	10.3	7.8	7.7
Annual Indicator	12.1	7.9	7.4	7.5	7.5
Numerator	19463	12707	11903	12064	12064
Denominator	160849	160849	160849	160849	160849
Is the Data Provisional or Final?				Final	Provisional
	2005	2006	2007	2008	2009
Annual Performance Objective	7.4	7.3	7.2	7.1	7

a. Last Year's Accomplishments

Title V staff participated in CHIP and Medicaid outreach activities through a Robert Wood Johnson Family Foundation "Covering Kids and Families" grant awarded to Dakota Medical Foundation.

Title V staff monitored enrollment levels in CHIP and Medicaid.

MCH and CSHS provided information to county social service staff and local public health departments about CHIP and Medicaid enrollment and application procedures.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Title V staff will continue to participate in CHIP and Medicaid outreach activities through a Robert Wood Johnson Family Foundation "Covering Kids and Families" grant awarded to Dakota Medical Foundation.				X
2. Title V staff will monitor enrollment levels in CHIP and Medicaid.				X
3. MCH and CSHS staff will provide information to county social service staff and local public health departments about CHIP and Medicaid enrollment and application procedures.				X
4.				
5.				
6.				

7.				
8.				
9.				
10.				

#### b. Current Activities

Title V staff will continue to participate in CHIP and Medicaid outreach activities through a Robert Wood Johnson Family Foundation "Covering Kids and Families" grant awarded to Dakota Medical Foundation.

Title V staff will monitor enrollment levels in CHIP and Medicaid.

MCH and CSHS staff will provide information to county social service staff and local public health departments about CHIP and Medicaid enrollment and application procedures.

#### c. Plan for the Coming Year

Title V staff will continue to participate in CHIP and Medicaid outreach activities through a Robert Wood Johnson Family Foundation "Covering Kids and Families" grant awarded to Dakota Medical Foundation.

Title V staff will monitor enrollment levels in CHIP and Medicaid.

MCH and CSHS staff will provide information to county social service staff and local public health departments about CHIP and Medicaid enrollment and application procedures.

**Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.***

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	82	87.5	87	93	80
Annual Indicator	75.3	63.0	78.3	79.8	75.7
Numerator	23763	23029	27653	30702	30995
Denominator	31552	36575	35328	38494	40950
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	80.5	81	81.5	82	82.5

#### a. Last Year's Accomplishments

MCH and CSHS continued to meet regularly with Medicaid and ND Health Track staff.

Title V staff analyzed utilization and cost trend data for children enrolled in the ND Health Tracks program.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH and CSHS will continue to meet regularly with Medicaid and ND Health Tracks staff.				X
2. Title V staff will analyze utilization and cost trend data for children enrolled in the ND Health Tracks program.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

MCH and CSHS will continue to meet regularly with Medicaid and ND Health Tracks staff.

Title V staff will analyze utilization and cost trend data for children enrolled in the ND Health Tracks program.

**c. Plan for the Coming Year**

MCH and CSHS will continue to meet regularly with Medicaid and ND Health Tracks staff.

Title V staff will analyze utilization and cost trend data for children enrolled in the ND Health Tracks program.

**Performance Measure 15: *The percent of very low birth weight infants among all live births.***

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1	1	1	1	1
Annual Indicator	1.2	1.1	1.2	1.1	1.2

Numerator	90	252	267	268	289
Denominator	7747	22975	23095	23395	23904
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	1.1	1	1	1	1

#### a. Last Year's Accomplishments

Ongoing, collaboration with the FAS and Healthy Pregnancy Task Force.

Funding is still being provided to all of the nine OPOP sites.

OPOP All-Staff meeting was held in September. Another All-Staff meeting is planned for September or October 2005.

OPOP data collected and distributed as needed.

Nutritional educational materials distributed to OPOP and WIC staff to their clients.

The resource guide entitled, "Services Offered to Women and Children by Public and Private Agencies Statewide" is posted on the MCH website. This resource can also be downloaded.

#### Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH staff will continue to participate in the activities of the FAS Task Force and to encourage primary prevention activities by the task force.				X
2. MCH will continue partial funding to the nine OPOP sites.	X			
3. WIC will continue nutritional education to women receiving WIC services.		X		
4. Statewide OPOP meeting will be held annually.				X
5. Will continue to gather data on birth outcomes and associated risk factors using the OPOP computer data program.				X
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

WIC will provide nutritional education to women receiving WIC services.

Provide partial funding to the nine public health units that administer OPOP.

MCH staff will participate in the activities of the FAS Task Force and to encourage primary

prevention activities by the task force.

Collaborate with appropriate partners to support the efforts in reducing VLBW babies.

Coordinate statewide meetings of OPOP coordinators and staff.

Gather data on birth outcomes and associated risk factors using the OPOP computer data program.

A resource guide entitled, "Services Offered to Women and Children by Public and Private Agencies Statewide" will be posted on the MCH website.

### c. Plan for the Coming Year

MCH staff will continue to participate in the activities of the FAS Task Force and to encourage primary prevention activities by the task force.

MCH will continue partial funding to the nine OPOP sites.

WIC will continue nutritional education to women receiving WIC services.

Statewide OPOP meeting will be held annually.

Will continue to gather data on birth outcomes and associated risk factors using the OPOP computer data program.

**Performance Measure 16:** *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	25	19.5	15.7	11	10.5
Annual Indicator	14.4	11.2	8.7	6.2	9.9
Numerator	7.67	18	14	10	16
Denominator	53356.3	160350	160854	160854	160854
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	9.8	9.5	9	8.5	8

### a. Last Year's Accomplishments

Continued coordinating and chairing the State Adolescent Suicide Prevention Task Force.

Continued coordinating with Mental Health Association of North Dakota by co-sponsoring a North Dakota Suicide Prevention Conference with 240 participants.

Began the process of updating the North Dakota Suicide Prevention Plan to expand the focus from adolescents to all ages.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue coordinating and chairing the State Adolescent Suicide Prevention Task Force.				X
2. Assist the Mental Health Association of ND in identifying funding to continue its suicide prevention efforts.				X
3. Continue work on the "State Plan for Adolescent Suicide Prevention" to include information on suicides for all ages.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Continue coordinating and chairing the State Adolescent Suicide Prevention Task Force.

Assist the Mental Health Association of ND in identifying funding to continue its suicide prevention efforts.

Update the "State Plan for Adolescent Suicide Prevention" to include information on suicides for all ages.

**c. Plan for the Coming Year**

Continue coordinating and chairing the State Adolescent Suicide Prevention Task Force.

Assist the Mental Health Association of ND in identifying funding to continue its suicide prevention efforts.

Continue work on the "State Plan for Adolescent Suicide Prevention" to include information on suicides for all ages.

**Performance Measure 17:** *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	54	64	64	59	60
Annual Indicator	59.1	58.0	53.9	51.7	45.0
Numerator	52	51	48	46	50
Denominator	88	88	89	89	111
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	50	51	52	53	54

## a. Last Year's Accomplishments

Continue to monitor this performance measure

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. Continue to monitor.				X
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

## b. Current Activities

Continue to monitor this performance measure

## c. Plan for the Coming Year

Continue to monitor this performance measure

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	85.5	86	86.5	85	85.5
Annual Indicator	85.0	84.5	85.5	86.5	84.9
Numerator	6523	6478	6627	6900	6937
Denominator	7676	7664	7755	7976	8173
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	86	86.5	87	87.5	88

**a. Last Year's Accomplishments**

PRAMS data distributed December of 2005.

MCH will continue to provide partial funding to the nine OPOP sites within the state.

OPOP staff will provide educational resources to clients. Additional materials (fact sheets and brochure) are available on our website.

MCH attend the March of Dimes and Healthy Pregnancy Task Force meetings.

OPOP data distributed statewide.

MCH continues to provide funding for Spirit Lake Sioux program at Fort Totten to provide prenatal care, infant care and immunizations, Trenton Indian Health Center to support Healthy Start and Indian Health Center coordination, Three Affiliated Tribes WIC program to coordinate WIC, Healthy Start and Indian Health Services Prenatal activities.

**Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribute PRAMS data as requested.				X
2. MCH will continue to provide partial funding to the nine OPOP sites within the state.	X			
3. OPOP sites will continue to provide educational material to clients.			X	
4. OPOP contact information and a resource guide entitled, "Services Offered to Women and Children by Public and Private Agencies Statewide" are posted on the MCH website.			X	
5. OPOP data will be distributed statewide on prenatal care and birth				X

outcomes.				
6. MCH will continue to provide funding for Spirit Lake Sioux program at Fort Totten to provide prenatal care, infant care and immunizations, Trenton Indian Health Center to support Healthy Start and Indian Health Center coordination, Three Affiliated T				X
7. Coordinate statewide meetings of OPOP coordinators and staff.				X
8.				
9.				
10.				

#### b. Current Activities

Distribute PRAMS data when available.

MCH will provide partial funding to the nine OPOP sites within the state.

OPOP sites will provide educational material to clients.

OPOP contact information and a resource guide entitled, "Services Offered to Women and Children by Public and Private Agencies Statewide" are posted on the MCH website.

OPOP data will be distributed statewide on prenatal care and birth outcomes.

Provide funding for Spirit Lake Sioux program at Fort Totten to provide prenatal care, infant care and immunizations, Trenton Indian Health Center to support Healthy Start and Indian Health Center coordination, Three Affiliated Tribes WIC program to coordinate WIC, Healthy Start and Indian Health Services Prenatal activities.

Coordinate statewide meetings of OPOP coordinators and staff.

#### c. Plan for the Coming Year

Continue to distribute PRAMS data as requested.

MCH will continue to provide partial funding to the nine OPOP sites within the state.

OPOP sites will continue to provide educational material to clients.

OPOP contact information and a resource guide entitled, "Services Offered to Women and Children by Public and Private Agencies Statewide" posted on the MCH website.

OPOP data will be distributed statewide on prenatal care and birth outcomes.

MCH will continue to provide funding for Spirit Lake Sioux program at Fort Totten to provide prenatal care, infant care and immunizations, Trenton Indian Health Center to support Healthy Start and Indian Health Center coordination, and Three Affiliated Tribes Healthy Communities Project.

Coordinate statewide meetings of OPOP coordinators and staff.

## D. STATE PERFORMANCE MEASURES

State Performance Measure 3: *The rate (per 1,000) of abuse and neglect in infants and*

children from birth to age 5.

**Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective	6.0	7.8	7.8	8.1	7.3
Annual Indicator	8.3	8.2	7.4	7.5	8.4
Numerator	397	392	350	355	401
Denominator	47613	47613	47613	47613	47613
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	7.2	7.1	7	6.9	6.8

**a. Last Year's Accomplishments**

The newborn home visiting committee has not met.

Continue to distribute the Parenting Newsletter to parents within North Dakota

All issues of the Parenting Newsletters have been updated and revised, including photographs.

The North Dakota Directory for Infant and Early Childhood Home Visiting Programs has not been updated due to a lack of funding.

Annual Infant Massage Network meeting held on May 5, 2004. Continue to plan a network meeting in May of 2005.

Staff continues to participate and facilitate the monthly Forms Committee meeting. Committee creates new fact sheets as needed.

Staff continues to work collaboratively with the CCHC.

Continue to provide funding to Local Public Health Units for their Newborn Home Visiting Programs.

Created new SIDS brochures and flyers for the American Indian population.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

<b>Activities</b>	<b>Pyramid Level of Service</b>			
	<b>DHC</b>	<b>ES</b>	<b>PBS</b>	<b>IB</b>
1. The newborn home visiting committee has not met.				X

2. Continue to distribute the Parenting Newsletter to parents within North Dakota.			X	
3. All issues of the Parenting Newsletters have been updated and revised, including photographs.			X	
4. The North Dakota Directory for Infant and Early Childhood Home Visiting Programs has not been updated due to a lack of funding.				X
5. Annual Infant Massage Network meeting held on May 5, 2004. Continue to plan a network meeting in May of 2005.				X
6. Staff continues to participate and facilitate the monthly Forms Committee meeting. Committee creates new fact sheets as needed.				X
7. Staff continues to work collaboratively with the Childcare Health Consultants.				X
8. Continue to provide funding to Local Public Health Units for their Newborn Home Visiting Programs.		X		
9. Created new SIDS brochures and flyers for the American Indian population.			X	
10.				

#### b. Current Activities

The newborn home visiting committee will meet as needed.

Update and distribute the Parenting the First Year Newsletter to parents of newborns within North Dakota.

Distribute the North Dakota Directory for Infant and Early Childhood Home Visiting Programs.

The Forms Committee will meet regularly to update the Child Health Services Manual. The Committee will develop any New Mother or Baby fact sheets as needed.

MCH will host a yearly Infant Massage meeting to share current information on infant massage.

MCH will continue to work with CCHC as needed.

Sixteen Local Health Departments use funds for a Newborn Home Visiting Program.

#### c. Plan for the Coming Year

Performance measure will be retired. No plan for the coming year.

State Performance Measure 4: *Increase the percent of normal weight among young adults 18-24 years of age.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual					

Performance Objective	46	47	48	55	58
Annual Indicator	53.2	53.2	53.3	57.5	57.4
Numerator	35146	35146	39095	42233	42629
Denominator	66053	66053	73349	73449	74267
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	59	60	61	62	63

#### a. Last Year's Accomplishments

MCH nutritionist continued as Department liaison for the Promoting Healthy Weight -- Nutrition Priority area of the Healthy North Dakota Initiative. Strategic plans for all three workgroups were developed: breastfeeding; fruit & vegetable; healthy school nutrition environment. The Healthy North Dakota Third Party Payer Work Group and Worksite Wellness Work Group were involved in discussions with the Nutrition and Physical Activity Work Groups.

MCH nutritionist facilitated meetings and projects of the Healthy Weight Council, and help to coordinate the activities of both the Nutrition and Physical Activity Work Groups of Healthy North Dakota Initiative. Recommendations for ND school weighing and measuring practices were not written.

MCH staff held two face-to-face meetings and one conference call with local MCH nutritionists. Staff from Child Nutrition Programs, Prevention Block Grant Programs, 5 A Day, 5 + 5 Communities, ND Healthy Heart Council, Midwest Dairy Council, ND Extension Service, etc. participated in the meetings/calls.

MCH nutritionist helped plan 5 + 5 Community Coalitions training for the fall of 2003.

The WIC program did receive funding to implement a research study of the use of motivational interviewing to change dietary and physical activity behaviors, with funding continuing until fall 2006.

#### Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MCH nutritionist continued as Department liaison for the Promoting Healthy Weight – Nutrition Priority area of the Healthy North Dakota Initiative. Strategic plans for all three workgroups were developed: breastfeeding; fruit & vegetable; healthy s				X
2. MCH nutritionist facilitated meetings and projects of the Healthy Weight Council, and help to coordinate the activities of both the Nutrition and Physical Activity Work Groups of Healthy North Dakota Initiative. Recommendations for ND school weighin				X
3. MCH staff held two face-to-face meetings and one conference call with local MCH nutritionists. Staff from Child Nutrition Programs, Prevention				X

Block Grant Programs, 5 A Day, 5 + 5 Communities, ND Healthy Heart Council, Midwest Dairy Council, ND Exten				
4. MCH nutritionist helped plan 5 + 5 Community Coalitions training for the fall of 2003.				X
5. The WIC program did receive funding to implement a research study of the use of motivational interviewing to change dietary and physical activity behaviors, with funding continuing until fall 2006.				X
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

MCH nutritionist will continue coordinating meetings of the Healthy Weight Council and distributing nutrition, physical activity and obesity related e-mails to the group.

MCH nutritionist will continue as Department liaison for the Promoting Healthy Weight -- Nutrition Priority areas of the Healthy North Dakota Initiative (HND). Strategic plans for all three workgroups will be developed: breastfeeding; fruit & vegetable; healthy school nutrition environment.

MCH nutritionists and other HND nutrition committee members will work with the North Dakota Workforce Safety and Insurance staff to develop criteria for a worksite wellness incentive program.

The MCH nutritionist and members of the HND nutrition committees will work with the HND Third Party Payer Work Group to develop reimbursement for nutrition and physical prevention interventions, as well as for related Medical Nutrition Therapy that are not currently covered.

State and local MCH nutritionists will work with 5 A Day consultant and ND Cooperative Extension Service to implement a nutrition wellness initiative for participants of the ND Public Employees Retirement System (PERS) -- Note: PERS includes all state employees, not just those that are retired.

State and local MCH nutritionists will work with Cardiovascular Healthy Program, 5 A Day consultant and ND Cooperative Extension Service to support and expand activities of the local 5 + 5 Community Coalitions.

The ND WIC Program will implement a USDA research project on motivational interviewing that includes several obesity related behaviors as evaluation components (i.e. decreasing TV viewing, increasing consumption of skim/1% milk, etc.).

MCH nutritionist will hold two face-to-face meetings and one conference call with local public health nutritionists. Staff from Child Nutrition Programs, Prevention Block Grant Programs, 5 A Day, Cardiovascular Health, Midwest Dairy Council, ND Extension Service, etc. will be invited to participate in these meetings/calls.

The state MCH and local public health nutritionists will work with the MCH Oral Health Program on the weighting and measuring component in the Oral Health Survey of 1st -3rd graders in the fall of 2004.

c. Plan for the Coming Year

Performance measure will be retired. No plan for the coming year.

State Performance Measure 5: *Percent of Medicaid-eligible children who receive dental services as part of their comprehensive services.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	33.5	37	37.5	29	31
Annual Indicator	35.2	31.2	28.8	30.2	25.7
Numerator	11106	11417	10192	11638	10509
Denominator	31552	36575	35328	38494	40950
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	32	33	34	35	36

a. Last Year's Accomplishments

Complete ND 3rd Grade Basic Screening Survey. Data collection will be completed by the end of the 2004-2005 school year, data analysis will be completed by the end of 2005.

All data is being assembled into a burden document, this will enable the oral health program to determine where the gaps in data exist.

Fact sheets are currently being developed regarding the OPOP program.

Project will show materials will be re-marketed by mailing to various groups with instructions on who to use the materials. The oral health program will work with the Bridging the Dental Gap Clinic in Bismarck ND to test market materials as needed.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Complete ND 3rd Grade Basic Screening Survey. Data collection will be completed by the end of the 2004-2005 school year, data analysis will be completed by the end of 2005.				X
2. All data is being assembled into a burden document, this will enable the oral health program to determine where the gaps in data exist.				X

3. Fact sheets are currently being developed regarding the OPOP program.			X	
4. Project Will Show materials will be re-marketed by mailing to various groups with instructions on who to use the materials. The oral health program will work with the Bridging the Dental Gap Clinic in Bismarck ND to test market materials as needed.			X	
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Use information gathered from the Head Start Oral Health Forum to develop or acquire educational materials. Integrate this information into current curriculums as well.

Market project will show to Public Health Providers as well as social workers, hospital clinics etc.

Work with Bridging the Dental Gap to market the clinic and to make sure patient data is collected so outcomes can be measured.

**c. Plan for the Coming Year**

Performance measure will be retired. No plan for the coming year.

State Performance Measure 6: *Ratio of school nurses to students in North Dakota.*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	.82	.18	.15	.2	.2
Annual Indicator	0.2		0.2	0.2	0.3
Numerator	18.1		21	21	31
Denominator	117329		112255	112255	107564
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	.2	0.3	0.3	0.3	0.3

**a. Last Year's Accomplishments**

Facilitated the March, June, August, and October 2004 planning for the North Dakota School Nurses Organization (NDSNO) meetings.

Facilitate/co-chair the School Health Interagency Workgroup (SHIW) meetings. SHIW is now meeting every other month (6 times a year).

Resources are provided to the NDSNO quarterly meetings and via the school nurse listserv.

Updated the ND school nurse fact sheet and will be updating the scoliosis booklet in the next couple months.

Education provided to various state groups/agencies on the new Coordinated School Health Programs grant.

The Dakota Medical Foundation (project funder) for the Model School Nursing Project has contracted with the North Dakota State University to evaluate this project.

Attend various state task forces/ workgroups (i.e. State Asthma Workgroup, Healthy Weight Council, Suicide Prevention Task Force) representing school nursing.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Facilitated the March, June, August, and October 2004 planning for the North Dakota School Nurses Organization (NDSNO) meetings.				X
2. Facilitate/co-chair the School Health Interagency Workgroup (SHIW) meetings. SHIW is now meeting every other month (6 times a year).				X
3. Resources are provided to the NDSNO quarterly meetings and via the school nurse listserv.				X
4. Updated the ND school nurse fact sheet and will be updating the scoliosis booklet in the next couple months.				X
5. Education provided to various state groups/agencies on the new Coordinated School Health Programs grant.				X
6. The Dakota Medical Foundation (project funder) for the Model School Nursing Project has contracted with the North Dakota State University to evaluate this project.				X
7. Attend various state task forces/ workgroups (i.e. State Asthma Workgroup, Healthy Weight Council, Suicide Prevention Task Force) representing school nursing.				X
8.				
9.				
10.				

**b. Current Activities**

Facilitate the planning for the quarterly North Dakota School Nurses Organizational (NDSNO) meetings.

Provide resources to the school nurses at the quarterly meetings and via the list serve.

Attend the quarterly School Health Interagency Workgroup (SHIW) meetings.

Edit the "Chalkboard on Health" school nursing newsletter.

Update school nursing information/resources as needed (i.e., ND school nursing fact sheet, scoliosis booklet).

Continue to serve as liaison for the Model School Nursing Project between the Dakota Medical Foundation (project funder) and Judith Igoe (project evaluator).

Serve as the school nursing representative on various state task forces/workgroups (i.e., State Asthma Workgroup, Health Weight Council, BELSS).

Apply for non-profit status through the North Dakota Secretary of State and tax-exempt status through the IRS for the North Dakota School Nurse Organization.

### c. Plan for the Coming Year

Performance measure will be retired. No plan for the coming year.

## State Performance Measure 8: *The proportion of pregnancies that are intended*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective		60.6	61.2	61	62
Annual Indicator		60.6	60.6	61.9	61.9
Numerator		641	641	557	557
Denominator		1058	1058	900	900
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	63	64	65	66	67

### a. Last Year's Accomplishments

Federal dollars were provided to nine delegate agencies supporting 21 clinic sites across North Dakota. It is estimated that services were provided to 16,000 women and men.

Family Planning outreach brochures were provided upon demand to all human service and social service office. Approximately 40,000 brochures were provided.

Services are strengthening at the satellite sites on Standing Rock and Spirit Lake. Outreach

continues on Three Affiliated Tribes reservation. Work is progressing at establishing a satellite site on Turtle Mountain reservation.

Two sites are providing services to incarcerated women. Jamestown provided services to women at the James River Correctional facility and with the move of this population to the new New England facility, they will transition their efforts to the county jail. Fargo provided services to women at the Cass County jail.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Federal dollars were provided to nine delegate agencies supporting 21 clinic sites across North Dakota. It is estimated that services were provided to 16,000 women and men.	X			
2. Family Planning outreach brochures were provided upon demand to all human service and social service office. Approximately 40,000 brochures were provided.			X	
3. Services are strengthening at the satellite sites on Standing Rock and Spirit Lake. Outreach continues on Three Affiliated Tribes reservation. Work is progressing at establishing a satellite site on Turtle Mountain reservation.	X			
4. Two sites are providing services to incarcerated women. Jamestown provided services to women at the James River Correctional facility and with the move of this population to the new New England facility, they will transition their efforts to the coun	X			
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

Provide federal grant dollars to the delegate agencies using the State funding formula.

Provide NDFPP outreach brochures to Regional Human Service Centers.

Continue to expand services to the American Indian reservations within ND - Standing Rock, Three Affiliated Tribes, Spirit Lake and Turtle Mountain - by providing on-reservations medical and educational services.

Final report of focus group study on the four reservations and Indian Service Area reviewed and presentations made to staffs of the Family Planning delegate agencies. Strategic plans for implementation of recommendations will be developed over the next year.

Distribution of the final report from the PRAMS study with focus on unintended pregnancy will be presented to Family Planning delegate agencies as well as public health.

Provide services to the women in correctional facilities -- James River Correctional Center and

Stutsman County Correctional Center in Jamestown and Cass County Jail and Juvenile Detention Center in Fargo.

c. Plan for the Coming Year

Performance measure will be retired. No plan for the coming year.

State Performance Measure 9: *Percent of women who use tobacco during pregnancy*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		19.0	19	16.5	16
Annual Indicator	17.9	16.6	17.2	16.0	16.0
Numerator	1375	1273	1335	1276	1309
Denominator	7676	7664	7755	7976	8173
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	15.5	15	14.5	14	14.5

a. Last Year's Accomplishments

Statewide OPOP data distributed to the nine OPOP Coordinators.

Smoking and Pregnancy materials were distributed at all OPOP sites.

Collaborated with the State Tobacco Prevention and Control program to distribute information about the Quitline and 5 A's Training.

OPOP Director became a committee member of the Provider's Partnership for Tobacco Prevention and Cessation for Women of Reproductive Age.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Statewide OPOP data distributed to the nine OPOP Coordinators.				X
2. Smoking and Pregnancy materials were distributed at all OPOP sites.			X	
3. Collaborated with the State Tobacco Prevention and Control program to distribute information about the Quitline and 5 A's Training.				X

4. OPOP Director became a committee member of the Provider's Partnership for Tobacco Prevention and Cessation for Women of Reproductive Age.				X
5.				
6.				
7.				
8.				
9.				
10.				

#### b. Current Activities

Collaborate with the State Tobacco Prevention and Control program to provide smoking cessation information to OPOP, WIC, PHUs and Indian Health Services clients.

Share WIC PNSS data on prenatal smoking with State Tobacco Prevention and Control program for distribution to local tobacco programs.

WIC staff will participate on the advisory committee for the tobacco quit line.

OPOP Director will distribute statewide OPOP data on smoking and pregnancy to OPOP Coordinators and Tobacco Prevention and Control program.

OPOP Director will provide educational materials to the OPOP sites on smoking and pregnancy.

#### c. Plan for the Coming Year

Performance measure will be retired. No plan for the coming year.

State Performance Measure 10: *Rate per 100,000 of pediatric hospitalization for asthma in children age 1 through age 17*

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		72.4	72.3	70	69
Annual Indicator	70.2	70.2	70.2	70.2	70.2
Numerator	317	317	317	317	317
Denominator	451459	451459	451459	451459	451459
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009

Annual Performance Objective	68	67	66	65	64
------------------------------------	----	----	----	----	----

## Notes - 2002

Three-year average beginning with 1999 data.

### a. Last Year's Accomplishments

CSHS continues to provide and/or pay for specialty care services for children with asthma. In FFY 2004, CSHS paid claims for 21 children with asthma through the diagnostic and treatment programs. CSHS also provided financial and technical assistance to support the development of a regional asthma clinic.

CSHS staff coordinated efforts for an asthma web cast held in October 2003 that provided training on NIH asthma guidelines. 69 providers attended the training and 31 sites were connected via computer.

A CSHS staff member continues to lead the ND State Asthma Workgroup. Quarterly meetings were held. CSHS staff assisted ND Department of Health staff in development of a CDC asthma planning grant application, which was approved but not funded.

CSHS staff monitored childhood asthma prevalence through a state-added childhood asthma module to the BRFSS. 2002 results indicated 9.7 percent of ND children have asthma. Preliminary 2004 results indicate a prevalence of 8.0 percent. A variety of studies have been completed that address health care utilization of Medicaid eligible children.

CSHS staff attended CDC's national asthma conference in April 2004 where a poster presentation on the ND asthma desk guide and action plan was conducted. CSHS coordinated the development, printing, and initial distribution of nearly 2,500 ND asthma action plans, desk guides, and quick-reference asthma management guidelines to providers in the state.

### Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHS will continue to provide and/or pay for specialty care services for children with asthma.	X			
2. Provide asthma education & training including NIH guideline training.				X
3. CSHS will collaborate with other stakeholders involved with asthma.				X
4. CSHS will monitor prevalence of childhood asthma in the state and service utilization for Medicaid-eligible children.				X
5. CSHS will promote the distribution and utilization of asthma action plans.			X	
6.				
7.				
8.				
9.				
10.				

### b. Current Activities

CSHS will continue to provide and/or pay for specialty care services for children with asthma.

CSHS will collaborate with other stakeholders involved with asthma (e.g.) workgroup participation, educational opportunities, legislation, etc.

CSHS will monitor prevalence of childhood asthma in the state and service utilization for Medicaid-eligible children.

CSHS will promote the distribution and utilization of asthma action plans.

**c. Plan for the Coming Year**

Performance measure will be retired. No plan for the coming year.

**State Performance Measure 11: *The percent of CSHCN served by CSHS with a specialty care visit***

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
<b>Annual Objective and Performance Data</b>	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Annual Performance Objective		87.6	88.1	90	91
Annual Indicator	87.3	88.0	88.9	87.6	87.5
Numerator	4498	4331	4166	3932	3750
Denominator	5152	4923	4688	4487	4288
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	92	93	94	95	96

**a. Last Year's Accomplishments**

CSHS continues to provide diagnostic and treatment services to eligible uninsured and underinsured CSHCN. During FFY 2004, CSHS served 107 children through the diagnostic program and 210 children through the treatment program.

CSHS supported ten different types of clinics, three of which were managed by state CSHCN staff and seven that were funded through service contracts. 271 children received contracted clinic services and 849 children received services through clinics directly managed by CSHS staff.

CSHS staff facilitated a statewide clinic coordinators meeting in August of 2004. New members participated in the clinic coordinators meeting. State CSHCN staff provided ongoing technical assistance throughout the year to clinic contract providers.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHS will provide diagnostic and treatment services to eligible uninsured and underinsured CSHCN	X			
2. CSHS will directly manage and fund a variety of multidisciplinary clinic services for CSHCNs and their families.	X			
3. CSHS will collaborate with other stakeholders to enhance the multidisciplinary clinic infrastructure in the state by conducting a clinic coordinator meeting.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

CSHS will provide diagnostic and treatment services to eligible uninsured and underinsured CSHCN.

CSHS will directly manage and fund a variety of multidisciplinary clinic services for CSHCNs and their families.

CSHS will collaborate with other stakeholders to enhance the multidisciplinary clinic infrastructure in the state by conducting a clinic coordinator meeting.

**c. Plan for the Coming Year**

Performance measure will be retired. No plan for the coming year.

**State Performance Measure 12: *The percent of reproductive age women who use a multivitamin or folic-acid containing supplements***

Tracking Performance Measures [Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]					
Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		42	54	57	58
Annual Indicator	52.7	52.5	56.2	57.2	60.3
Numerator	62581	61652	62916	61442	67578

Denominator	118817	117408	111919	107325	111991
Is the Data Provisional or Final?				Final	Final
	<b>2005</b>	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>
Annual Performance Objective	59	60	61	62	63

**a. Last Year's Accomplishments**

State and local MCH nutritionists continued to work with ND Extension Service on the folic acid promotion.

Data from the 2003 PRAMS and 2002 BRFSS survey on pre-pregnancy vitamin consumption was only recently available so the MCH Fact Sheet on Pre-Pregnancy Vitamins has not been developed yet.

**Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet**

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. State and local MCH nutritionists continued to work with ND Extension Service on the folic acid promotion.			X	
2. Data from the 2003 PRAMS and 2002 BRFSS survey on pre-pregnancy vitamin consumption was only recently available so the MCH Fact Sheet on Pre-Pregnancy Vitamins has not been developed yet.				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**b. Current Activities**

State and local MCH nutritionists will continue to work with ND Extension Service their folic acid promotion project.

Data from the 2003 BRFSS survey on pre-pregnancy vitamin consumption will be shared with partners.

**c. Plan for the Coming Year**

Performance measure will be retired. No plan for the coming year.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective		24.5	24.5	15	14.5
Annual Indicator	20.9	15.4	14.4	16.9	17.1
Numerator	36.7	81	76	89	90
Denominator	175375	526125	526125	526125	527412
Is the Data Provisional or Final?				Final	Final
	2005	2006	2007	2008	2009
Annual Performance Objective	14	13.5	13	12.5	12

a. Last Year's Accomplishments

On an ongoing basis, the program provided technical assistance to local entities and the general public on a variety of injury prevention topics (playground safety, child passenger safety, poison control, shaken baby syndrome, product safety).

Four editions of the "Building Blocks to Safety" newsletter with a "Buckle Update" section were printed and mailed to approximately 1700 individuals.

The program collaborated with several North Dakota agencies and organizations including, EMSC, state and local Safe Kids Coalitions, the Native American Injury Prevention Program at United Tribes College, School Health Interagency Workgroup, ND Farm Bureau, Governor's Traffic Safety Coordinating Committee, and Healthy North Dakota.

The program served as the state representative to the US Consumer Product Safety Commission by re-distributing CPSC recall information and conducting 10 recall effectiveness checks.

The program participated in the North Dakota Child Fatality Review Panel by categorizing deaths to all children under age 18 for in-depth or cursory review, by doing an in-depth review of all motor vehicle cases and presenting them to the full panel, and by participating in full panel meetings.

Approximately 44 children with elevated blood lead results were tracked.

The Department of Career and Technical Education promoted Shaken Baby Syndrome prevention within their programs. SBS was promoted during October. Public health agencies displayed information and distributed brochures to clients.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Service			
	DHC	ES	PBS	IB
1. On an ongoing basis, the program provided technical assistance to local entities and the general public on a variety of injury prevention topics (playground safety, child passenger safety, poison control, shaken baby syndrome, product safety).				X
2. Four editions of the "Building Blocks to Safety" newsletter with a "Buckle Update" section were printed and mailed to approximately 1700 individuals.			X	
3. The program collaborated with several North Dakota agencies and organizations including, EMSC, state and local Safe Kids Coalitions, the Native American Injury Prevention Program at United Tribes College, School Health Interagency Workgroup, ND Farm				X
4. The program served as the state representative to the US Consumer Product Safety Commission by re-distributing CPSC recall information and conducting 10 recall effectiveness checks.				X
5. The program participated in the North Dakota Child Fatality Review Panel by categorizing deaths to all children under age 18 for in-depth or cursory review, by doing an in-depth review of all motor vehicle cases and presenting them to the full panel,				X
6. Approximately 44 children with elevated blood lead results were tracked.				X
7. The Department of Career and Technical Education promoted Shaken Baby Syndrome prevention within their programs. SBS was promoted during October. Public health agencies displayed information and distributed brochures to clients.			X	
8.				
9.				
10.				

#### b. Current Activities

Provide technical assistance, training, data, and materials to local entities on injury-specific topics, i.e., playground safety, product safety, etc.

Distribute media releases and produce a quarterly newsletter, "Building Blocks to Safety" with a "Buckle Update" section.

Collaborate with state and local Safe Kids Coalitions, Emergency Medical Services for Children, Native American Injury Prevention Coalition and other private/public partners on injury prevention projects.

Coordinate/contract with the US Consumer Product Safety Commission to educate the public about product recalls, conduct recall effectiveness checks, and complete special projects as assigned.

Participate in the ND Child Fatality Review Panel.

Do a cursory review of all deaths to children under age 18, assign for further review as appropriate, and conduct in-depth review of all motor vehicle cases.

Coordinate North Dakota's Poison Prevention education campaign. Work with Hennepin

County Poison Control Center in Minnesota to assure poison consultation coverage for North Dakota.

Establish and promote a Shaken Baby Syndrome Prevention Week.

Coordinate the ND Conference on Injury Prevention and Traffic Safety in November 2004.

Monitor blood lead levels reported to MCH. Track and manage elevated levels through local public health agencies.

#### c. Plan for the Coming Year

Re-apply for ND Department of Transportation funds to administer the state's child passenger safety program; monitor expenditures, complete reports as required.

Continue educational efforts to increase the proper use of car seats through use of pamphlets, posters, displays, etc. Sponsor Child Passenger Safety Week in February 2005.

Develop an educational campaign to inform North Dakota parents and caregivers about changes in the state's child passenger safety law. Provide information on the appropriate restraint for their child's age, weight, height, and developmental level.

Continue car seat distribution program throughout the state by providing car seats, policies/procedures, and training/technical assistance to local agencies. Provide car seats and training to five Indian reservations.

Assist local agencies in conducting car seat check-ups by providing certified instructors, technicians, car seats, and checkup supplies.

Continue coordinating the "Boost, Then Buckle" Campaign to encourage the use of booster seats by children from 40 to 80 pounds. Provide booster seats to local agencies to enhance the campaign.

Conduct 2-3 four-day NHTSA Standardized Child Passenger Safety Courses to certify new child passenger safety technicians. Conduct 2-3 refresher courses for current technicians and assist current technicians in meeting requirements for re-certification.

On an ongoing basis, provide technical assistance and updated information to technicians to maintain technical knowledge on child passenger safety issues. Write the "Buckle Update" section of the "Building Blocks to Safety" quarterly newsletter to provide current information on child passenger safety.

## E. OTHER PROGRAM ACTIVITIES

The Domestic Violence/Rape Crisis Program provides grants to domestic violence/rape crisis, law enforcement, courts and prosecutorial agencies to reduce and prevent violence against women.

The Family Violence Prevention and Services Program assists in establishing, maintaining, and expanding programs and projects to prevent family violence and to provide immediate shelter and related assistance for victims of family violence and their dependents. Grant funds are distributed on a formula basis to 17 of 19 domestic violence/rape crisis agencies and to the state domestic violence coalition. Uses for the funds include: providing group and individual counseling; community, school, and professional prevention education presentations; funds crisis lines; and, providing emergency shelter for victims of domestic violence.

Rape Crisis grant funds provides services to victims of sexual assault. These funds are distributed on an equal basis to 17 of the 19 domestic violence/rape crisis agencies to manage crisis lines and provide services to victims of sexual assault.

Rape Prevention and Education grant funds are used to educate communities about sexual assault and to develop programs to prevent it. These funds are distributed on a formula basis to 19 domestic violence/rape crisis agencies to support educational seminars, crisis hotlines, training programs for professionals, development of informational materials, and special programs for underserved communities. The state domestic violence/sexual assault coalition also receives funds to implement prevention projects for middle schools and campuses on a statewide basis.

Safe Haven funds are used to help create safe places for visitation with and exchange of children in cases of domestic violence, child abuse, sexual assault, or stalking. The ND Council on Abused Women's Services (NDCAWS) (state domestic violence/sexual assault coalition) and five local visitation centers receive funds to build an infrastructure of a statewide network of providers and enhance and strengthen local services to families.

Grants to Encourage Arrest Policies and Enforcement of Protection Orders Program recognizes domestic violence as a crime that requires the criminal justice system to hold offenders accountable for their actions through investigation, arrest, and prosecution. NDCAWS has been contracted to oversee management of the project. NDCAWS will collaborate with Minot State University's Rural Crime and Justice Center and the Northern Plains Tribal Judicial Training Institute, and a multidisciplinary advisory team from local law enforcement, domestic violence/rape crisis, tribal and prosecution agencies to assist in implementing the grant goals. The grant goals are to develop a model law enforcement domestic violence policy for North Dakota, develop a train-the trainer curriculum on local policy development, and create a pool of officers to serve as technical assistance and training resources for local law enforcement agencies and community response teams.

The Stop Violence Against Women formula grants program encourages the development and strengthening of effective law enforcement and prosecution strategies to address violent crimes against women and the development and strengthening of victims' services in cases involving violent crimes against women. Funds are allocated to 19 domestic violence/rape crisis agencies.

## **F. TECHNICAL ASSISTANCE**

Technical assistance has been requested for the following:

- 1) Program evaluation - Currently, there is limited Title V staff capacity, expertise or experience in this area. Specific state programs would need to be identified that could potentially benefit from process or outcome evaluation research.
- 2) NPM #03 Medical Home - Assistance is needed to assure progress in this national performance measure, which will require moving from informational/promotional activities to implementation with very limited resources. North Dakota is comparable to the United States in the percent of CSHCN who receive care in a medical home based on national SLAITS CSHCN survey data; however, only 44% of respondents in North Dakota indicated receiving effective care coordination when needed.
- 3) NPM #06 Transition - Assistance is needed to achieve the goal of enhancing youth transition. National SLAITS CSHCN survey data indicated only 3.3% of CSHCN received services necessary to make transitions to adult life. Efforts could initially focus on transition from pediatric to adult health care.

## **V. BUDGET NARRATIVE**

### **A. EXPENDITURES**

Please refer to the attached Word document.

### **B. BUDGET**

Please refer to the attached Word document.

## **VI. REPORTING FORMS-GENERAL INFORMATION**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. GLOSSARY**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. TECHNICAL NOTE**

Please refer to Section IX of the Guidance.

## **X. APPENDICES AND STATE SUPPORTING DOCUMENTS**

### **A. NEEDS ASSESSMENT**

Please refer to Section II attachments, if provided.

### **B. ALL REPORTING FORMS**

Please refer to Forms 2-21 completed as part of the online application.

### **C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS**

Please refer to Section III, C "Organizational Structure".

### **D. ANNUAL REPORT DATA**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.